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Curated by
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Investing in Malaysia's care future

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In June and September 2024, ISIS Malaysia hosted two public engagements centred on the care economy. The editors wish to record our thanks to all participants at the roundtables.

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Foreword

Before the first light, she is already awake. Quietly, she moves through the house like clockwork. She prepares breakfast, getting her two young children ready for school and helps her ageing mother get out of bed, offering assistance with daily tasks. Then, her attention shifts to her husband, who is recovering from a minor injury, ensuring that he has everything he needs before he heads out the door for work.

Only once her family are taken care of does she begin her paid shift. But by then, she has already put in half a day of work. Her own tasks are woven around the needs of those she cares for – children, husband and elderly parents who rely on her for support with daily activities.

Her story is not unique. It is the lived reality of millions, including Malaysians – mostly women – who shoulder the hidden architecture of our society: unpaid care.

To truly grasp the impact of caregiving, consider this: in 2022, if care constraints that prevent participation in the labour force were removed, it would enable Malaysia to gain 3.2 million workers in paid employment and 4.9 percentage points in gross domestic product (GDP) growth in the year alone. Such constraints include the limitations faced because of caregiving and domestic responsibilities that are usually unpaid and expected to be done without compensation. These obligations often prevent people, particularly women, from participating fully in the formal labour market. The numbers are clear. The care economy is not a footnote to growth – it is a foundation.

This stark reality, as highlighted in the Institute of Strategic & International Studies (ISIS) Malaysia's previous policy report, "Building a cradle-to-grave care economy for Malaysia", underscores the urgency and transformative potential of investing in the care economy, particularly given the country's rapidly ageing demographics.

This latest publication affirms the care economy's untapped potential as a new driver of economic growth and lays out four transformative lessons to realise this vision: professionalising the care sector, foster inter-ministerial collaboration to dismantle siloed approaches, adopting a contextualised care framework suited to Malaysia's diverse needs and building a robust care ecosystem that supports all generations.

As part of our ongoing commitment to deepen the national discourse on the care economy, ISIS Malaysia, alongside senior visiting fellow Denison Jayasooria, convened a series of public engagement events over the past year. These include a roundtable entitled "Conversations on the care economy in Malaysia" (26-27 June 2024) and "Growing the economy and meeting the care needs of the Malaysian society" conference (24-25 September 2024).

The discussions brought together subject-matter experts from various fields that illuminated the care economy's challenges and aspirations. They underscored the importance of a comprehensive, inclusive and sustainable approach to care provision that acknowledges the interdependence of different care sectors and the individuals they serve.

The outcome of these public engagements is a comprehensive publication that encapsulates a broad range of issues within the care economy. This book stands as both a reflection of collective expertise and a call to action for a society that values care as a fundamental pillar of economic and social wellbeing. It covers the current care economy landscape, needs of various groups that require care and the shared structural solutions for future directions in Malaysia.

As the philosopher Nancy Fraser once wrote: "In the era of the family wage, care work was treated as the private responsibility of individual women. Today, however, it can no longer be treated in that way."

Indeed, care is a public good. It is in this spirit, that we hope this book can drive evidence-based policymaking and offer actionable avenues towards a more inclusive care economy in Malaysia. Let this be the beginning of a shift – towards a society where no one must choose between dignity, decent work and caring for the ones they love. A future where care is not a silent sacrifice, but a shared responsibility, supported by systems that honour its worth.

Mohd Faiz Abdullah
ISIS Malaysia Chairman

Introduction

Yvonne Tan and Ahmad Farhan

The demand for care in Malaysia is surging. This trend is driven by several factors, including rapid ageing, changing family structures, rural-to-urban youth migration, inadequate labour market policies (that are sensitive to caregiving needs) and underdeveloped care infrastructure. The Institute of Strategic & International Studies (ISIS) Malaysia's policy brief, "Building a cradle-to-grave care economy for Malaysia", estimates that if unpaid care work produced in Malaysian homes every day were valued in national gross domestic product (GDP) figures, it would create about RM379 billion in value. As a standalone service subsector, it would form the largest sector after manufacturing in Malaysia.[1]

These unpaid care burdens have economic consequences, too, placing an overwhelming burden on women, with a significant portion of this work being unpaid and undervalued. About 3.2 million Malaysians remain outside the labour force or in part-time work because of care obligations. Women overwhelmingly dominate this group of caregiving individuals in Malaysia (98%).[2]

As such, it is essential to redefine care as a collective responsibility, recognising it as not just a women's issue or a welfare concern but as a bedrock of Malaysia's continued social and economic advancement.[3] To this end, care must be viewed as fundamental rights and providing adequate support for those unable to care for themselves is vital for the health and welfare of all Malaysians.

To frame the discussions set forth in this book, we draw on definitions from ISIS Malaysia's policy brief.

Care work includes: 1) direct, personal and relational care, such as caring for children, ill partners and relatives, and; 2) indirect care, such as cooking and cleaning.

Care economy, which consists of productive work – either in paid or unpaid labour – and services that support caregiving in all its forms, primarily for dependent groups like children, the elderly, the disabled and the ill.[4]

Care work as a key driver of economic development.

Investing in social infrastructure (comprising of healthcare, education, childcare and long-term adult care) is essential to growing the economy's productive capacity. Currently, Malaysia ranks low globally in public spending relative

to its level of economic development, with insufficient investment in these key social sectors.[5] Health, education and social assistance spending has fallen below both regional averages and the average for its income group.[6] This lack of funding further exacerbates the challenges faced by caregivers and those who require care, highlighting the urgent need for policy reform and increased investment in social welfare.

Research has indicated that investing in the care industry generates substantial positive employment and output outcomes.[7] Additionally, the United Nations Development Programme's (UNDP) landscape analysis report on Malaysia shows that increased public sector investment in the care economy could generate high impacts on GDP (by 6%), employment rate (9%) and income levels (11%), further strengthening the case for a formalised care economy.[8]

There is growing recognition of this urgency. At the time of writing, the Ministry of Women, Family and Community Development (MWFCD) is in the process of refining the preliminary draft of the Malaysian care industry action plan. In addition, local governments are following suit, with the Selangor government drafting an upcoming care economy policy.[9] Other states, like Perak, are also beginning to adopt similar strategies to build a robust care ecosystem.[10]

As public efforts to develop an inclusive care economy take shape, this publication seeks to reframe our understanding of care as an investment and a driver of economic growth, ultimately exploring how the nation could ensure equitable and improved care for all.

Each chapter concludes with recommendations aimed at government agencies, policymakers, researchers, academics, activists and community workers to help advance the care economy. Starting with an analysis of the care economy landscape, it draws on comparative insights and incorporates perspectives from those impacted directly.

In the first chapter, Denison Jayasooria of the All-Party Parliamentary Group Malaysia for Sustainable Development Goals (APPGM-SDG) offers a thorough overview of the care economy landscape in Malaysia. 'Literature, laws on care economy' examine policy papers and initiatives at the national, regional and global levels. Denison introduces a three-point framework: analysing current public policies and legislation, emphasising the care economy as a form of social investment and addressing gender as well as cultural dimensions. The chapter also puts forward key policy recommendations for the development and implementation of a national care economy policy.

As we begin to think concretely about what a national policy might look like, Khairil Izamin's chapter, 'From Global South to Malaysia: review of care economy in Malaysia', draws lessons from countries addressing similar challenges. He identifies three key issues: coordination issues between different levels of govern-

ment and agencies, the dual impact of the professionalisation-commodification nexus and the influence of traditional gender norms. The chapter examines how countries, such as Brazil, Cuba and Indonesia – which face similar shortcomings in social care provisions and a lack of investment in care infrastructure – have approached these issues.

While Khairil's chapter compares international approaches, Teo Sue Ann's chapter, 'Local, regional realities in care economy', focuses on the specific challenges within Malaysia. The chapter particularly looks at the regional dynamics and disparities among states and localities, as well as the urban-rural divide. She argues that revitalising the care economy must account for Malaysia's heterogeneous society, with its diverse needs of care, ensuring that everyone could benefit equally.

The second section delves into specific target groups, including people with disabilities (PWDs), older persons, children in need and people with mental health concerns.

Chapter four, 'On community-based rehab centres' challenges', by Lydia Ann Bill, Sapura Arshad and Mohd Fouzi Mohd Isa, examines the challenges faced by pertubuhan pemulihan dalam komuniti (community-based rehabilitation – PPDK) centres in supporting PWDs. It highlights infrastructural and workforce-related issues, such as staffing constraints, lack of professional services and inadequate infrastructure, all of which hinder the effectiveness of care support provided to PWDs and broader community development.

Chapter five, 'Care economy and older persons in Malaysia: long-term care in ageing society' by Rahimah Ibrahim and Chai Sen Tyng of the Malaysian Research Institute on Ageing (MyAgeing®), focuses on the impact of the ageing population on long-term care. Malaysia's demographic shift towards an older population demands urgent attention and action from all sectors of society, with the traditional caregiving model becoming increasingly unfeasible. The need for long-term care requires a wide range of services, from assistance with daily tasks to more complex medical supervision, highlighting the importance of developing a robust and accessible long-term care infrastructure.

The next chapter, 'Evaluating provision of care for children' by Anisa Ahmad of House of Wisdom and Debbie Ann Loh of APPGM-SDG, hones in on evaluating the provision of care for children in childcare centres, kindergartens and care centres. Given that childcare services have been shown to positively impact female participation in the labour market, their recommendations on legislation, workforce, child protection and regulations remain crucial. The chapter also features a key case study on care for traumatised, neglected and vulnerable children, which provides valuable insights into the experiences and challenges faced by providers of childcare services.

The last target group is explored in 'Care of persons with psychosocial disabilities' by Andrew M Chandrasekaran of the Malaysian Mental Health Association and Laura Kho Sui San of the Mental Health Association of Sarawak. Given the stigma and discrimination against individuals living with mental health conditions, they have limited access to services or receive quality care. Andrew and Kho offer future directions for psychosocial care, which include key requirements of care and social workers and the recognition of care workers. Highlighting the role of social workers in addressing complex social issues, such as child protection, family violence, mental health stigma and poverty, the chapter underscores the importance of this workforce and organisations in bridging the gap in access to health and social care services.

The final section looks at directions to develop Malaysia's care economy, addressing the shared structural and operational challenges faced by the four key target groups.

In 'Case for professionalising social care', Teoh Ai Hua of the Malaysian Association of Social Workers and Universiti Utara Malaysia outlines professional standards and trainings necessary for the social care industry. This chapter underscores how the underdevelopment of the social care workforce has resulted in issues, such as low wages, workforce shortages and inconsistent care quality, all of which impede on the sector's growth.

The concluding chapter, 'Care economy as a growth sector' by Teo Lee Ken of APPGM-SDG, positions the care economy as a growth sector. Teo proposes key recommendations for building a welfare system that aligns with the changing needs of Malaysian society in accordance with relevant SDGs.

Key lessons

The publication offers four lessons.

First, professionalising the care sector in Malaysia must be prioritised. This includes harmonising fragmented legislation, streamlining regulations and developing a national care act. This in turn will allow for the formalisation of minimum standards, skills, training, qualifications, clear career pathways and remuneration, all of which are critical to developing a skilled and compassionate care workforce.

Second, a commitment to inter-ministerial co-operation and strategic partnerships among various sectors – formal, informal and voluntary – is crucial. These collaborations are necessary for the planning and development of care provisions. Cooperation plays a key role in addressing policy gaps, as well as the implementation, monitoring and evaluation of care. This is especially important for children, older persons, PWDs and individuals with mental health concerns, especially those from low-income communities.

Third, the need for a contextualised approach to care is essential, considering cultural and religious considerations, regional differences, gender concerns and the specific care needs of various groups. The lived realities nationwide, including perspectives from Sabah and Sarawak, cannot be ignored. Macro-level policies must serve micro-level needs and service provisions.

Finally, a robust, coherent, accountable and responsive care ecosystem is essential for creating a sustainable, inclusive and expansive care economy. This ecosystem must allow for autonomy, benefiting care providers, care recipients and caregivers. This necessitates strong governance, sustainable financing, innovation, and effective collaborations and partnerships, as well as ensuring a rights-based approach in meeting the evolving needs of Malaysian society.

Advancing Malaysia's care economy is essential for both its social well-being and economic growth. As the country continues to confront the challenges of changing demographics and growing demand for care, this publication aims to contribute towards moving the needle in Malaysia's care economy agenda to address its evolving care needs. By influencing future policies, economic growth and strategies, it seeks to improve the quality and equity of care for all, both in policy and practice.

1

Literature, laws on care economy

Government needs to step in as demographic trends challenge traditional patterns of informal care

Denison Jayasooria

1.1 Introduction

Care economy is emerging as a priority in development planning because of demographic shifts and the urgency to address effectively society's most vulnerable and their needs. These include the elderly, children, persons with disabilities (PWDs) and those with mental health issues.

It is significant to note that there are heightened calls for the care economy at the global, regional and national levels. This includes Malaysia. In July 2023, Minister for Women, Family and Community Development (MWFCD) Nancy Shukri announced that the care economy will be incorporated into national development and economic planning.[1] She recently affirmed that an action plan on the care economy is being formulated for the development of the care industry.[2]

This chapter will review and analyse 12 key research articles and policy documents. Drawing from this set of literature, the next section will discuss and expand on a three-point framework developed on public policies and legislation for the care economy, care economy as an industry, and its gender and cultural dimensions. The chapter ends with key policy recommendations, including calls on policymakers to recognise the care economy as an opportunity to grow a new economic sector, to professionalise the care workforce and for societal paradigm shifts as well as cultural support towards building a more gender equal, inclusive and equitable society.

1.2 Literature review

Table 1.2.1 comprises of 12 key research articles, activities and policy documents authored or organised by academics, think-tanks, policymakers and United Nations (UN) agencies. A review is undertaken below to provide an overview of what topics or issues transpired in these materials. This process is paramount as it allows us to identify the core themes, prevailing thematic gaps and ways to chart the direction of Malaysia's care economy.

Table 1.2.1. Key research articles and policy documents on care economy

Author/convenor (year)	Title	Description
Institute of Strategic & International Studies (ISIS) Malaysia (2024)	Building a cradle-to-grave care economy for Malaysia[3]	A comprehensive review of care needs across the lifespan
The Asia Foundation (2023)	Care economy dialogue: towards a resilient and sustainable care economy in Malaysia[4]	An eight-page paper with key points and way forward for care economy
Khazanah Research Institute (KRI) (2019)	Time to care: gender inequality, unpaid care work and time[5]	A detailed paper quantifying paid and unpaid care work
United Nations Development Programme (UNDP) (2023)	Investing in the care economy: opportunities for Malaysia[6]	Overview highlighting potential investment approaches towards strengthening care economy
ISIS Malaysia (2024)	Roundtable discussions: conversations on the care economy in Malaysia[7]	A two-day (26-27 June 2024) conversation among academics, government agencies, civil society and non-governmental organisation (NGO) actors
UNDP (2024)	Malaysian care economy: landscape analysis[8]	A comprehensive analysis of the needs, challenges, recommendations and case studies for care ecosystem
UN Women Regional Office for Asia and the Pacific (2023)	The Asia-Pacific care economy forum: how can an inclusive and resilient care ecosystem be built?[9]	A regional perspective on care economy with relevance for Malaysia
ASEAN Secretariat (2022)	The ASEAN comprehensive framework on care economy[10]	A framework providing six strategic priorities to support care economy regionally
UN Economic and Social Commission for Asia and the Pacific (2022)	How to invest in the care economy: a primer[11]	Focuses on SDG 5 on gender equality and women empowerment

International Labour Organisation (ILO) (2024)	Resolution concerning decent work and the care economy[12]	Adopts position that care work is decent work and outlines its role
World Economic Forum (WEF) (2024)	The future of the care economy[13]	A global business perspective on the economic value of care economy
International Trade Union Confederation (2016)	Investing in the care economy: a gender analysis of employment stimulus in seven Organisation for Economic Co-operation and Development (OECD) countries[14]	A gender analysis of employment stimulus in seven OECD countries, with a strong focus on public investment

Drawing from these 12 papers, three key points pertaining to Malaysia's care economy and its future directions are identified.

First, reviewing public policies and legislation for the care economy is key to providing an analysis of Malaysia's care economy landscape. This could serve as a timely contribution to the national agenda and priorities in improving care. For example, the lack of professional care workers adversely impacts on the quality of care for those in need. This calls for the need to professionalise the care workforce.

Second, viewing the care economy as an industry. Here, there is a need for policymakers to recognise care as a social investment rather than an expenditure. There is much potential in the care economy as a new source of economic growth, jobs and income creation. Many case studies from other countries support this notion of the care economy as a social investment, which could open new possibilities for Malaysia.[15]

Third, the gender and cultural dimensions of the care economy must be considered. Women are disproportionately affected by the burden of informal and unpaid care work. In Malaysia, it has been reported that 98% of those who have had to reduce work hours or withdraw from the workforce because of care responsibilities are women.[16] Gender stereotypes and cultural beliefs further undervalue the unpaid care work of women and deepen inequality. These call for societal paradigm shifts and cultural support towards building a more gender equal, inclusive and equitable society.

1.3 Care policies and legislation for care economy

I. Policies

The National Social Policy (NSP 2030), launched on 21 October 2024, is a significant public policy in Malaysia's care economy. It is considered as an "umbrella policy framework supporting the government's efforts and strategies to strengthen social development, ultimately making Malaysia more prosperous and harmonious."[17] It shows the government's commitment to providing a solid base for social policies, setting the nation's social direction by identifying and addressing social issues holistically. NSP 2030 integrates 44 social policies formulated by 19 federal ministries.

It is within the framework of NSP 2030 that a care economy policy is to be drafted. This is in response to consistent calls made by ISIS Malaysia and other social policy advocates for a national care economy blueprint, a related roadmap and a national care act.[18] Such a national policy must be holistic, taking a lifecycle approach to care from cradle-to-grave while integrating social care into social protection provisions with a clearly defined roadmap.[19]

In formulating a care policy, reference is made to public goods theory in the field of economics.[20] Public good is seen as the government's role, where it is expected to provide goods and services that are inclusive for all, unlike private goods and services. A public good is defined "as a commodity or service that every member of society can use without reducing its availability to all others."[21] A public good is typically provided by a government and funded through taxes. Examples include roads, parks, schools, national defence and basic needs, such as access to clean air and drinking water.

With regard to the care economy, a major shift in public policy is needed, especially in the use of public funds. Under this logic, care should no longer be considered as a public spending but rather a social investment into a public good that will facilitate economic growth.[22] This is also in line with SDG 5.4, which advocates through "appropriate investments in care infrastructure, social protection systems and public services as a way of promoting shared responsibility."[23] Such a goal is relevant on both the national level (Malaysia) as well as regional (Asia-Pacific).

The idea of the care economy as a public good is advocated by ISIS Malaysia.[24] Here, the public sector or government, through its development budget, must begin by recognising and valuing care as a public good, as a service it provides. The challenge lies in cultural perceptions, where social care is regarded as the domain of the personal and family, and not a public sector. However, literature on the care economy advocates for greater state involvement to ensure that the

new challenges faced by families can be addressed. Therefore, public investment is necessary to enhance both national progress and human wellbeing.

II. Legislation on care

The need for legislation was highlighted at ISIS Malaysia's roundtable discussions in June 2024. This includes provisions for the protection of children, the elderly and PWDs, including regulations to monitor and evaluate care quality. It is noted that adopting a human rights approach to the care economy is possible as Malaysia acceded to the UN Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of the Child in 1995 and Convention on the Rights of Persons with Disabilities in 2010.[25] These conventions provide a solid human rights basis for policies and legislation with direct implications for the provision of services.

Currently, there are only legislations pertaining to the elderly, women and children. These need to be reviewed and enhanced to meet international standards and requirements. For the elderly, relevant acts include the Care Centres Act 1993 (Act 506) as well as Private Aged Healthcare Facilities and Services Act 2018 (Act 802).[26]

The KRI paper provides a good write-up on regulating childcare centres through the Child Care Centre Act 1984 (Act 308).[27] The 2007 amendments were primarily on the administrative aspects of childcare centres, including extending the validity of operating licences from 12 months to 60 months.[28] This act governs four types of centres – home-based childcare with fewer than 10 children, workplace childcare centres, community-based childcare centres and institution-based childcare centres with 10 or more children. The questions raised include the sufficiency of these provisions, access, affordability and quality of care. The paper also indicates that 98.8% of Malaysians opted for informal childcare because of convenience, flexibility and affordability.[29] While there are different provisions for centres, there is no overarching legalisation or policy, which is urgently needed.

III. Policies and legislation to professionalise care work

Within the context of policies and social legislation, there is a need to discuss professional care workforce policies and the Social Work Profession Bill. Teoh Ai Hua raised matters pertaining to the urgently needed Social Work Profession Bill, which is salient to promote the professional nature of social work. He draws a distinction between social workers and care workers. He notes that "care workers typically engage directly with clients in daily activities and

personal care, (whereas) social workers engage with the welfare system to effect broader changes."[30] Their complementary roles within the care ecosystem are thus acknowledged.

However, the promised legislation on social work was delayed for 14 years and could only be tabled in 2025, provoking reactions from civil society as well as NGOs. Activists say postponing the tabling of the Social Work Profession Bill is a "travesty", urging the government to pass the bill as soon as possible "to safeguard the welfare of vulnerable groups in our society."[31]

Meanwhile, The Asia Foundation highlights the need to professionalise care work and address issues of access, especially to childcare facilities by all segments of society. In addition, it noted how care work is undervalued. There is also a call for a blueprint on care economy, citing the ASEAN document. Furthermore, it calls for a whole-of-society collaboration in developing Malaysia's care economy. In a similar way, the ILO paper recognises the heterogeneous nature of care work noting that "care work is highly demanding and often requires high level of skills and specialised knowledge."[32]

Training to build a competent workforce could be at the basic certificate and diploma levels or at the degree and postgraduate levels. It could range from technical vocational education and training (TVET) skills training to more specific training, such as supporting emotional wellbeing. While the care worker seems to be focused on domestic duties, they also need to learn basic competencies. This includes how to provide rights- and value-based care for the elderly, children and PWDs, treating them with compassion and patience. At the same time, there must be a clear learning pathway from certificate to diploma to degree and postgraduate studies in care work. Only then will this facilitate career progression and better remuneration.

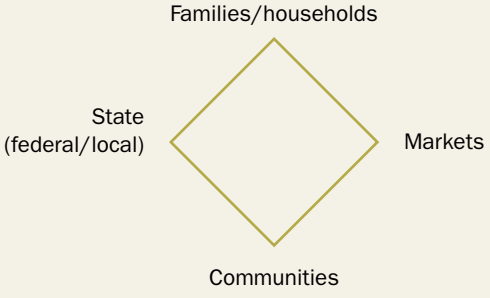
Complementing this is ISIS Malaysia's roundtable discussions that highlighted the need for professional services, especially among the various target groups. There is a need to move beyond custodial care to upskilling the workforce with higher competencies to address their socio-psychology needs. In addition, during the ISIS Malaysia care economy roundtable, it was raised that care and social workers must also be equipped to handle technological innovations. This matter was raised by Fatimah Zuraidah Salleh, a key representative from MWFCD.

The Ministry of Human Resources (MOHR), MWFCD and Health Ministry (MOH) must recognise care and social work as professions contributing to the economy and provide guidelines for salaries and working conditions. This will revitalise the job market and encourage Malaysians to seek a career in the care and social work sectors. Opportunities to move towards specialisations in caring for the elderly, children, PWDs and those with mental health concerns must also be presented.

IV. Policies and legislation to foster multi-stakeholder partnerships

There are four main institutional actors or stakeholders: the state, markets, households and communities.[33] This can be represented by a care-diamond diagram (Fig. 1.3.1).[34] This is also aligned with the thrust in SDG 17.17, which calls for multi-stakeholder partnerships of public-private and civil society partnerships.

Fig. 1.3.1 Care diamond



Source: Razavi[35]

There is a need to increase the number of care providers across the private (social enterprise), voluntary and community sectors. The increase in private nursing homes and care homes for the elderly is a significant phenomenon, especially in urban centres. In a similar way, the voluntary and community sectors providing care services have also increased.

However, the latter lack resources and personnel. There must be a shift from informal care to more formal and organised care. Private providers, in particular social enterprises, expressed concern at the ISIS Malaysia roundtable that the registration process and requirements were hostile to new operators. This necessitates changes to encourage those in the informal sector to register.

ILO has also underscored the potential of the social and solidarity economy (SSE) organisations in the care sector.[36] SSE refers to enterprises, organisations and cooperatives engaged in economic, social and environmental activities to serve a collective good. It is premised on voluntary cooperation and mutual aid, democratic and/or participatory governance, autonomy and independence, with an emphasis on people and social purposes over capital in the distribution and use of surpluses and/or profits.[37]

ILO also maintained that in the absence of viable public and private providers, cooperatives serve as an innovative option to close this gap. "Cooperatives provide multiple services (like day care, childcare, foster care and mental or de-

velopmental healthcare) to distinct populations, including elders, children and adolescent youth, and persons living with disabilities or illnesses (mental and/or physical)."[38] This subject will be further explored below.

1.4 Care economy as industry

The potential of the care economy is well documented by WEF, which states that "care underpins the entire global economy – it is an engine for growth, prosperity and wellbeing and is the foundation of social life."[39] Investing in the care economy today is critical to ensure an inclusive, sustainable and resilient future. This assessment on the global economy is significant and, therefore, provides the economic and business viability of the care sector as future markets. Here, WEF notes that investment into the social infrastructure improves social capital mobility and economic connectedness.[40] It also has the multiplier effect, which promotes overall gains.[41]

I. Care economy as vehicle of growth

Many researchers, including those in ISIS Malaysia, have argued that the care economy should be recognised as a potential driver of economic growth. Proponents of such a view estimate that the value of unpaid care work in gross domestic product (GDP) terms could reach RM379 billion.[42] This is the largest service sub-sector after manufacturing if valued in GDP terms.

The KRI 2019 paper calls for development planners to reframe care economy, not just to help increase women's participation in the labour market, but to also view it as a source of economic growth.[43] Likewise, the UNDP 2024 report recognises the potential of the care economy as "a new source of economic growth and job and income creation for the country." In a nutshell, by creating incentives to boost the care economy, the government can create economic and social ripple effects beyond its initial intervention costs."[44]

In the context of economic potential, The Asia Foundation presents the idea of the "silver economy", referring to all economic activities, products and services designed to meet the needs of people older than 50.[45] This concept – derived from the so-called silver market that emerged in Japan (the country with the highest percentage of people over 65) during the 1970s – brings together such diverse sectors as health, banking, automotive, energy, housing, telecommunications, leisure and tourism, among others.[46] Currently, the percentage of those above 65

years in Malaysia stands at 7.7% of the population and is projected to increase, holding promising growth potential for the silver economy.[47]

A new dimension identified in the literature review is the UNDP's SDG investor map (SDG IM), which is an effort to mobilise private sector capital to advance SDGs. SDG IM recognises "personalised and regular caregiving services for various needs as a key area in the health sector" and sees this dimension as an investment opportunity area. The thrust here is for a "business model for personalised caregiving services, including in-home care, companionship, personal hygiene, medication management and specialised care."[48] This is the social enterprise model that is recommended: to reiterate, the care economy must be seen as an investment and not a cost as it holds great potential to drive economic growth.

II. SSE: models and lessons for care economy

There have been discussions on alternative ways of doing business that tap on SSE's potential. While the free market is the dominant approach for businesses, there are initiatives that harness the potential of the community and resilience. In 2023 and 2024, the UN passed two resolutions on SSE and released a secretary-general's special report on SSE organisations on the ground providing the space for alternative economic development.[49]

There is potential for SSE-related organisations to take the driver's seat for the care economy, complementing the work of the government and the private sector, which could target the poor as well as sustainable initiatives. ILO has many good initiatives on this theme of decent work and care economy. Furthermore, ILO recognises and is providing global leadership in advancing the care agenda and a clear link "between the care economy, gender equality, decent work, sustainable development and social justice. It underscores the urgent need for action to ensure decent work within the care economy and to promote access to high-quality care and support for all."[50]

1.5 Gender and cultural dimensions of care economy

All the literature reviewed recognised that the burden of care work falls primarily upon women, which is often also unpaid work. In this context, The Asia Foundation highlights the issue that "women bear the burden of unpaid care responsibilities which translated to low labour participation and return to work rates."[51] Women are regarded as the informal carers of the elderly, children and PWDs. Meanwhile, unpaid care work widens gender inequalities and negatively affects women's participation in the labour market. The heavy reliance on informal care arrangements is also observed.

The KRI paper provides a useful executive summary with six key takeaways based on its findings: 1) unpaid care work is a pressing issue in the nation; 2) care work is undervalued; 3) women face the double burden of family and career; 4) unpaid care work has a negative impact on labour market outcomes; 5) formal childcare services are hampered by affordability and accessibility, and; 6) there is a need to strive towards gender equality in the workplace and at home. It also provides methods to measure unpaid care work to the value of market transaction.

The paper affirms women's "double burden". The fact is, women shoulder "more unpaid work than men despite working almost equal hours in paid employment." It is also clear that "additional hours of unpaid care work are associated with fewer hours of market work and less income."[53] Hence, if care constraints are removed, this would enable almost 3.2 million women to return to the labour force.[54]

UNDP has highlighted the potential of women's contribution in the labour market. However, they face many challenges in employment, negatively impacting on their labour force participation rate (LFPR) because of their caring responsibilities. This is regarded as a "disproportionate distribution of unpaid care responsibility based on biased social norms and gender stereotypes." [55]

The call here is to strengthen the care economy by adopting "a new vision of economics that recognises the importance of empowerment and the autonomy of women, who bear the brunt of unpaid care, to the functioning of the economics, the wellbeing of societies and life sustainability."[56]

Moreover, the Asia-Pacific care economy forum notes that care work as "invisible" as well as "a lost opportunity for economic advancement."[57] A report UNDP published refers to how care work is not being recognised as an economic activity and remains unrecognised and undervalued. It also highlights the concerns for the low and declining female LFPR, emphasising on ways to strengthen care delivery models through expanding the market dimensions of the care diamond diagram. To illustrate, one side of the two halves of the diamond would be

the non-market, namely government, family and non-government provisions. The other half comprises of the market – referring to businesses, investors and enterprise-delivery models.

Cultural norms have a strong bearing on the roles played by women and men in the care sector. The KRI paper highlights three global models.[58] The first is the male breadwinner model whereby the man in a household earns money while the woman serves as a homemaker. The second model is the universal breadwinner model where both men and women have jobs, whereby women have a double role, but men are also responsible for caring. The final model is the caregiver parity model, whereby the care work is compensated through greater state support through allowances and benefits. The KRI paper affirms that in Malaysia, it has traditionally been the first model.[59]

Therefore, the cultural dimension is a dominant factor in the care dynamic. This is echoed by the National Population and Development Board. However, the board notes that "among younger and older millennials, the concept of shared responsibility is more prevalent and acceptable to them compared to the generations before them. For the millennial generation, which will define the characteristics of the families of the future, many more said that men should be more involved in housework, childcare and eldercare compared to the generations before them."[60] This positive change demonstrates the breaking down of gender defined roles towards one of shared responsibility.

1.6 Recommendations

Drawing from the literature review and discussions on the care economy, we propose five key policy recommendations.

First, in the absence of a comprehensive care economy policy in Malaysia, there is a need to produce a national policy, roadmap and blueprint on the care economy. A clear policy statement is needed to accord care economy national recognition. The government has made an announcement on this and thus such instruments must be factored into development planning and featured in the 13th Malaysia Plan (2026-2030). There is a need to include social care into social protection schemes, especially provisions to benefit the elderly.

Second, formulate appropriate legislation to support the care economy, especially the recognition of care and social workers. Such legislation must cover professional aspects, terms and condition of services, including remuneration. Currently, unlike other care professions, such as nursing or counselling, social work and care work do not have any formal certification for professional practice.

The lack of recognition for social workers is hindering job creation in the care economy. There is, however, adequate training at the diploma and degree levels in social work. The career path for social workers is needed to ensure the development of the care sector in generic social work or specialised care.

Also, all legislations pertaining to the care of children, older persons, PWDs and persons with mental health issues should be reviewed to improve accessibility, affordability and quality of care.

Currently, it is stated that "Malaysia lacks consolidated legislation and policy on the care economy as well as regulatory framework to sustain a highly qualified social care workforce in the long term."[61] There is a need to put new policies in place to reverse this situation. There is clearly a need for a National Care Act where all the target groups are given the right to access care.[62] More importantly, an urgent review of the Social Work Profession Bill and Senior Citizens' Bill is due. Initially presented for first reading in 2023, these need to be activated to enact these as acts of parliament in 2025.

Third, recognise the care economy as a new growth area. This is vital for public funds to be released to build the social infrastructure that are similar to physical infrastructures. This will enhance job creation, investments and economic contributions from the care economy sector. Here, the Ministry of Economy (MOE) could play the lead role and facilitate economic advancement.

There is a need for greater private sector involvement and investment in this sector as they see the economic potential in international schools and hospitals, which means there is a potential to attract their involvement in the care industry. Currently, although social enterprises are active in delivering care services, they are small and do not operate as a collective the way the private sector can be mobilised by the Chamber of Commerce. Furthermore, ministries, such as the Ministry of Domestic Trade and Costs of Living as well as the Ministry of Entrepreneurship must be brought in alongside a service ministry, such as MWFCD.

Fourth, establish an inter-agency taskforce incorporating officials from MWFCD, MOHR, MOH, MOE and Ministry of Finance. This suggestion was made by Norma Mansor from Universiti Malaya when she called for greater collaboration between key agencies as a discussant at the care economy conference hosted by ISIS Malaysia.[63]

This multi-stakeholder taskforce is in line with SDG 17.17 on multi-stakeholder partnerships.[64] To complement the work of the taskforce, there is also a need to mobilise the private sector, academia, professional bodies (such as Malaysian Association of Social Workers), civil society, NGOs and consumer organisations in developing Malaysia's care economy.

The issue is while the government recognises the care economy, there is a lack of formal recognition of the care economy. During the Asia-Pacific care economy forum, the government agreed to follow up on these matters through

the establishment of a national process namely the Malaysian forum for the care economy. The focus will be centred on developing care as a sector through formulating "a care industry development fund, development human resources cadres and promoting training and education on care within universities."[65]

Fifth, address the cultural dimension and gender stereotyping through a wider public awareness and educational programme on gender literacy. This is the major challenge in Malaysian society – to address both cultural and religious views on the division of care responsibilities between men and women. Trained leaders and community health workers could be employed to facilitate these at the grassroots level. The power of messaging and social media should also be leveraged on. Besides, adapting care economy policies and initiatives so that they are more gender-sensitive and culturally respectful is equally important.

1.7 Conclusion

The review of the care economy literature reveals that there is much thinking on this theme at the national, regional and global levels. It is recognised that demographic trends, such as urbanisation and ageing population, are challenging the traditional patterns of informal and family-based care. There is, therefore, a need for a comprehensive range of services provided by the government and voluntary sector, especially to those who need assistance. There continues to be space and potential for paid care services among the middle- and upper-middle income groups in urban areas looking for quality care services. Investing in the care economy and building the talent pool is key.

One of the most significant points in this literature review is the untapped potential of care economy as a new driver of economic growth, as well as in addressing the wellbeing and welfare of everyday Malaysians, especially the vulnerable sections of our society.[66] The challenge for policymakers is not to see the care economy as a cost or expenditure but as a social investment. The potential of the sector is well documented and, therefore, social investment is needed urgently to develop the care workforce.

To this end, fostering inter-agency cooperation and strategic partnership among various sectors, including social enterprise, is imperative. Here, we can promote a mixed economy of care. There is also a need to recognise that in our diverse and plural society, certain cultural and religious groups still call for a strong involvement of the informal and family sector to continue to play a role. The gender concerns and addressing cultural stereotypes, which are deeply rooted in Malaysian society, must be confronted. For these reasons, schemes and pro-

grammes that can support and facilitate comprehensively the cultivation of the family unit in society are crucial. Hence, having comprehensively reviewed the key elements in the care economy, it is hoped that care will remain a national priority with progressive growth to provide quality care for all Malaysians.

2

Lessons from Global South on tackling care economy challenges

Brazil, Cuba and Indonesia offer lessons on inclusive and sustainable changes to social care model

Khairil Izamin Ahmad

2.1 Introduction

Growing the care economy has become a pertinent policy topic in Malaysia in recent years.

Several factors have informed ongoing debates about the best way to provide quality and equitable care services to all Malaysians. These include: 1) the fragmentation of social care provisions across agencies and governance levels; 2) the country's transition towards an ageing society; 3) challenges that women face in participating in the labour market, and; 4) the need for better regulation of the care sector as well as the legal recognition of the status of care professionals.

Malaysia's challenges are not unique, compared with other Global South countries, many of which have scrambled to address inadequacies and shortcomings in their social-care provisions. These challenges include changing demographics, gender-related issues and lack of investment in care infrastructure.

The aftermath of the Covid-19 pandemic has also influenced the sense of urgency among these countries, as the care economy is now considered a policy priority.

Furthermore, growing and strengthening the care economy will also safeguard future economic prosperity in any society.[1] The Malaysian government, in particular, considers the sector as a driver of future economic growth through a private sector-driven care market that offers products, such as care tourism, medical equipment and technologies.[2] This is already happening in the healthcare sector – Indonesians, for example, have been flocking to hospitals in Kuala Lumpur and Penang to seek medical services for years.

This chapter provides a cursory analysis of how selected Global South countries have tried to address the similar challenges confronting Malaysia. These are: 1) the fragmentation of service provision across different levels of government and agencies; 2) concerns surrounding the professionalisation of care work and the commodification of care, and; 3) problems of gender inequality and stigma towards care service.

The chapter highlights the examples of Brazil's social assistance programme, Cuba's social justice approach to social care and Indonesia's focus on challenging traditional gender assumptions about social care in its care economy blueprint.

2.2 Why learn from other Global South countries?

Historically, developed and industrialised countries in the Global North have enjoyed a head start in the development of the care economy over the Global South. Different aspects of social care have entered the policy discourses of many Global North societies since the post-World War II era as part of efforts to define the state's role in the provision of welfare support for the population.

It is, therefore, not surprising that models from the Global North, such as the Scandinavian welfare states, the United Kingdom, Australia and Japan have set the standards that others take as examples from which to learn.[3]

However, there is still a dearth of policy discussion in Malaysia focusing on the evolving approach to social care in relative context to its Global South counterparts. Not enough exercises have been conducted to draw the parallels of challenges faced by Malaysia and other countries or lessons we can learn from them. In addition, despite the thriving nature of the policy debate in the country, Malaysia is still far from addressing the challenges that it faces to strengthen its care economy, compared with many in the Global South.

Vital reforms, such as legislating and regulating the care profession, are long overdue and have been delayed for many years, leaving Malaysia behind other Global South countries, including its regional counterparts.[4] There is, therefore, room to learn from others that have tried to address the same challenges as Malaysia.[5]

2.3 Central database for care services

The fragmentation of social care services is one of the issues inhibiting Malaysia's efforts to provide seamless and equitable care services for everyone. At present, the provision of social care, although clearly defined according to the Department of Social Welfare's (Jabatan Kebajikan Masyarakat – JKM) list of vulnerable groups, is not necessarily accessible to all members of the population.

This is one of the issues highlighted by the All-Party Parliamentary Group Malaysia on Sustainable Development Goals (APPGM-SDG), which has conducted a mapping exercise to identify grassroots challenges faced by groups, such as the elderly and persons with disabilities, trying to access care services, including service shortage and scatteredness.[6]

A key factor that has contributed to service fragmentation is the challenge of coordinating between all constituent parts of the country's governance structure, which ranges from the federal to the state to local levels of government.

One of the most enduring political questions in a federal system of governance is how to effectively distribute powers to the federal (national) and state (subnational) governments. This is especially so in relation to fiscal responsibilities and how funds are shared as well as distributed among different constituents.

This question is especially important in trying to come up with a structure that would distribute development and public service benefits fairly between all parts of an administrative system, which is often complex and bound by rigid constitutional arrangements.[7]

Malaysia's dynamics revolve around similar issues and they feed into the different realms of the governance structure, including social care and welfare. They include, among others, overlapping and/or conflicting jurisdictions of federal and state governments, agencies and departments working in silos, and the lack of coordination between the different levels of government.

Although welfare is incorporated in the Concurrent List of the Federal Constitution, these issues have also affected the dispensation of social services, assistance and welfare. A contributing factor is the lack of coordination between care providers and the government, including JKM as the main welfare agency.[8]

Malaysia's federal government has, in recent times, worked towards establishing multiple integrated database systems containing information about the assistance and welfare needs of poor and vulnerable households. These range from the eKasih database in 2007 to the Central Database Hub (Pangkalan Data Utama – PADU) in 2023. Both systems, however, have been beset with issues, such as incomplete or inaccurate data (eKasih). They also suffer from the lack of buy-in and cooperation from the public and other stakeholders who are meant to self-report vital information to PADU.

Notwithstanding those issues, eKasih and PADU are vital to the process of rendering all types of assistance and care to the needy. The government has also recently reiterated its plan to consolidate various data hubs managed by federal ministries and state agencies into PADU by 2025 to ensure a more coordinated and data-driven decision-making.[9]

These databases, however, are meant to function primarily as information hubs from which different agencies determine the distribution of their respective service or assistance. The Implementation Coordination Unit (ICU) of the Prime Minister's Department, for example, is not responsible for the disbursement or distribution process – instead, it acts only as the custodian of eKasih data and provides information to other agencies. Indeed, there is a need to enhance the ICU's role to ensure better coordination across all the different providers.

I. Brazil's decentralised provision of social assistance

Brazil, one of the few federal countries in the Global South, has shown that a centralised database could be an opportunity to integrate social care services, while offering localised solutions via its Unified Social Assistance System (SUAS). This is done through the presence of a central agency that defines broadly the types of services or assistance that should be rendered to the needy. The agency also coordinates the distribution of assistance across all levels of government.

Far from centralising the provision of social assistance and care in the hands of the federal government, the SUAS model shows that it is possible for such a system to be the catalyst to define clearly the roles of the different levels of government in providing care services. It also helps generate a more coordinated and context-sensitive dispensation of care. In other words, while the system provides the guidelines for the types of services that must exist in all parts of the country, the responsibility is left in the hands of state or local governments that work within their respective contexts.

Brazil's history as a federation is one that has alternated in terms of the emphasis on centralisation and decentralisation. Its current constitution, drafted in 1988, has strong decentralisation tendencies compared with the 1967 version during the military dictatorship era, which emphasised the dominant and central role of the federal government.[10]

Brazil's 1988 constitution also generated a vision of welfare and social assistance from a public policy perspective – something that was previously left to the non-state domains.[11] This vision was one that is underpinned by the shared responsibilities of the union (i.e., federal), state and municipal governments in providing social assistance to the Brazilian population.

In 2005, the Brazilian government introduced SUAS to ensure effective and fair distribution of welfare and social assistance to all parts of the country. Although SUAS was introduced by the federal government, it does not operate in a top-down and centralised fashion. Rather, it is a system that organises and funds social assistance in a participatory fashion among all levels of government across the federation.[12]

As the Brazilian tax system heavily favours the federal government, SUAS facilitates the transfer of federal funds to state governments for the provision of social assistance. It also has a collaborative governance structure comprising of agencies across all levels of government. According to de Arruda, the system "lays out important enablers" to allow for the efficient coordination and dispensation of social assistance in an intergovernmental fashion.[13]

What is interesting about SUAS is that while it provides indicative guidelines to support the targeting of services and a list of typified services that are offered, it does not prescribe or spell out how state or local governments should

provide those services.[14] It, therefore, decentralises the provision of social assistance. At the same time, it also ensures overlapping symptoms as well as causes of socio-economic issues, such as poverty, are addressed simultaneously. Furthermore, it plays the role of managing the inclusion of new poor households into the Brazilian government's Unified Registry database, an equivalent to eKasih, as well as updating information of registered households.[15]

An implementing agency that coordinates – instead of directs – the distribution of social assistance across multiple levels of stakeholders is well suited for a country like Malaysia, which has been looking for a solution to streamline its welfare system. It also provides a platform for dialogue between public and non-governmental service providers, all of which move in the same direction in terms of welfare services they cover as provided in the list of national typified services.

In the Malaysian context, the beneficiaries of those services will also be clear in terms of the benefits that they will be able to access based on their needs. The types of service coverage will be standardised, whereby people, no matter where they live – in urban or rural areas – are able to access assistance via more locally driven approaches. The result will be a dynamic system that can accommodate more typified services in the future upon determination of their needs. It may also be a cost-effective way to provide care services to people living in different parts of the country.

2.4 Putting "value" into care profession

A major hurdle in Malaysia's development of care economy is the delayed tabling of the Social Work Profession Bill, despite pressure from stakeholders. The bill is intended to, among others, professionalise social workers through the introduction of mandatory licensing and registration. It also seeks to establish a competency framework and create a formal complaints mechanism for the social-care sector.[16] Without passing the bill into law, social workers will remain professionally unrecognised, while the care sector is left unregulated, thus posing risks to both social care workers and recipients.

The reason behind the delay in tabling the bill has continued to invite speculations. However, an oft-cited cause is the incorrect perception that care work is fundamentally voluntary and its professionalisation could kill its spirit of voluntarism. As stated by Denison, "(t)his is a pity as many policies do not see the urgency of the bill as there is a mindset that assumes a heart is all you need and volunteerism can resolve complex problems."[17]

A similar worry that may arise is related to the potential effect of the drive towards the marketisation of the care sector to derive its economic returns. While the discussion surrounding the Social Work Profession Bill is not connected directly to the economic discussion, it has, nonetheless, been argued that a professionalised workforce could be an enabler and beneficiary of a care economy market in Malaysia.[18]

Given the conflation, will for-profit orientation sideline the voluntary spirit of social care and become the motivating factor that spurs the sector instead?

I. Cuba's social-justice approach

Professionalisation and the spirit that comes with voluntarism do not have to be mutually exclusive, as we will see through the example of Cuba. Instead, the "heart" that Denison is referring to can go hand-in-hand with the service that a professional social worker renders to his clients. A professional social workforce does not mean that it is "heartless", regardless of the sphere within which they function – public or private, the government or the market.

Few Global South countries have managed to provide welfare and social benefits universally to their citizens, fewer still are more fascinating and studied than Cuba.[19]

The outcomes of Cuba's safety net provision, which includes free and universally accessible healthcare and education, worker housing and a comprehensive pension system, among others, have been overwhelmingly positive to the well-being of its society since it was instituted in the 1960s.[20] Among the achievements of Cuba's social-welfare model include the establishment of "a high quality primary care network and an unequal public health system", eradication of certain diseases, such as malaria, tetanus and measles, its emergence as the world's first country to eradicate mother-to-child transmission of human immunodeficiency virus (HIV) and congenital syphilis, attainment of universal literacy and a generous pension system with one of the widest coverages in Latin America.[21]

In Cuba, social workers operate at all levels of the system – national, provincial and local. According to Herman, Zlotnik and Collins, the workers perform "direct service, programme development, consultation, supervisory and administrative functions" with specific functions, such as "conducting assessments, determining eligibility for and connecting people with community resources, preventing and addressing social isolation and enhancing psychosocial well-being."[22] Social workers are also involved in the provision of family healthcare, playing a supervisory role alongside leaders of polyclinics, nursing supervisors, internists, paediatricians, obstetrician-gynaecologists and psychologists to oversee

family physician clinics as part of "basic work groups" responsible for reviewing the clinics' performance.[23]

Underlying the provision of social care in Cuba is a community-oriented approach. It is centred around the close relationship between social workers and their care recipients, which in turn is rooted in the government's promotion of "collective goals and community ties", stemming from its "historical commitment to advocating for social justice" and caring for downtrodden and powerless members of society.[24]

Informed by this commitment, Cuba also undertook reforms in the training of its social workers in the early 1970s by implementing a social-work educational programme to train practitioners by offering a university degree programme for experienced social workers. The aims are to professionalise them and establish social-work schools for youth where they can train to serve eventually their local communities.[25] As a result, Cuba has committed and professional groups of social workers.

This provides some interesting lessons to shape our thinking about the value that social care carries in Malaysia. "Value" does not refer to economic benefits nor indicators. Rather, it refers to the codes or standards that should be driving the way we provide care to the needy and vulnerable groups in society, as we transition from a traditional to a professional care workforce in the country.

Professionalising the care workforce is one of the key factors that is needed to transform the care economy in Malaysia, to ensure that the sector is staffed by qualified workers and aligned to other professional sectors in terms of regulation.[26] The outcome of this shift will be a better regulated care sector based on professional standards that move us away from traditional and unpaid care.

When this transformation takes place, the risk may be that the "value" aspect – the "heart" of social care – takes a back seat, especially if the policy focus leans strongly on the push towards the marketisation and commodification of care.[27] More specifically, as we attempt to transition away from informal and unpaid forms of social care, what kind of transformation do we want to see in the future? Furthermore, what should the transformative meaning of care be in the future?[28]

At present, this is a question that requires further exploration in public debates on reforming the Malaysian care economy. It is important to note that the performance of care work, even at the informal level, is not necessarily tied to its economic costs and outcomes. For many who perform care work at the informal level, the reasons might be for financial gains or more, which is tied to their moral functions. Recognising the moral dimension of care – and making sure it is captured as we transform and professionalise the care sector – will be an acknowledgement that the value of care is tied to both its economic justification as well as the notions of rights and justice.

Such notions are embedded in the Cuban social care model.[29] While social workers are professionally recognised, the ethos of social care in Cuba is one that is embedded in a sense of social justice. This is an important aspect to furnish the profession with, especially as those workers deal with impoverished and vulnerable groups on the ground.[30]

In transforming social care in Malaysia, especially at the grassroots and community levels, the emphasis on the transformative value of care should also be underscored even if there is a policy preference to move towards the marketisation of care. Drawing from the Cuban experience, the aim should be to foster support networks among communities and strengthen the bond between professional care workers and recipients, which would empower care workers to respond to local needs. This would allow for a more transparent diagnosis of what communities really require in terms of support and assistance.

2.5 Transforming traditional gender norms

One of the biggest sociocultural challenges in transforming the care economy in Malaysia lies in the prevailing traditional gender norms that expect women to carry the burden of care.[31] Thus far, the reform narrative has been one that emphasises the need for more accessible and affordable childcare facilities to facilitate greater women participation in the labour market so they would be able to leave their children in the hands of professional caregivers.[32]

While building a quality and accessible care ecosystem is important to reduce the burden of care on women, challenging gender inequality should also be on the Malaysian policy agenda. This is important to allow for fundamental and long-term shifts in the way gender roles are imagined by society, which would result in a fairer distribution of the burden of care between women and men.

Such reforms are already common in the Global North. The introduction of gender-equality legislations has shaped the ways in which gender roles are taught in school. Furthermore, labour market reforms have facilitated opportunities for men and women to attend to their family responsibilities through subsidised childcare, equal parental leave, and flexible working arrangements.[33] These are trends that Global South countries are trying to catch up on, albeit with varying degrees of speed and success.

The need to address the gendered division of care work has also been recognised by regional and national initiatives across the Global South. In ASEAN's pioneering report "Addressing unpaid care work in ASEAN", there is an acknowledgement of "shifting norms, cultural practices and individual behaviours" as

part of the six levers of change to reforming care policies in member states.[34] This involves a whole-of-society effort to challenge patriarchal assumptions about gender roles and shifting prevailing mindsets on caregiving in the region.

I. Indonesia's experience

The importance of including strategies to affect shifts in gender norms has also been recognised by Indonesia, which recently launched its Care Economy Roadmap 2025-2045.

The catalyst for this is the government's acknowledgement that Covid-19 had hit women and girls harder than others, resulting in its emphasis on addressing gender inequality as the central focus of the post-pandemic recovery plan.[35]

The roadmap lists seven priority areas to be addressed by 2045, including a commitment to establish more gender-equitable caregiving roles in Indonesian society. The seven priority areas are: 1) developing accessible, quality childcare services; 2) strengthening elderly and long-term care services; 3) improving inclusive, integrated care services for persons with disabilities, patients of HIV or AIDS, special-need individuals and other vulnerable groups; 4) enhancing maternity leave; 5) increasing the involvement of men, including enhancing paternity leave; 6) recognising decent work for care workers, and; 7) implementing social protection for workers in the care economy.[36]

Attempting to achieve all the goals that have been identified under the priority areas, the Indonesian government has also identified potential roadblocks that need to be overcome, including "restrictive social norms regarding men and women's roles in care provision and social and political resistance to change."[37]

Ultimately, in addition to transforming Indonesia's care economy, the roadmap aims to facilitate the creation of a gender-equal labour market and fairer access to work for women, something that has been neglected in national policy discussions.[38] This will be done through efforts to shift societal attitudes towards women's role in caregiving via public campaigns to address the stigma of care work, especially among boys and men, to foster a willingness to share the burden of caregiving in families and communities.

Such socially based initiatives, alongside information and advocacy campaigns will be complemented by policy and legislative measures to improve women political representation at all levels, as well as challenge and sanction harmful practices like gender-based violence.[39]

Like Indonesia, addressing the gendered aspect of caregiving is vital if Malaysia is to strengthen its care ecosystem meaningfully. As long as women shoulder a disproportionate burden of caregiving, they will also face barriers to contribute

to societal development, thus restricting the society's access to a much-needed resource pool to drive productivity.

According to a 2019 research by Khazanah Research Institute, while Malaysia has gradually evolved from a traditional to a universal breadwinner model of the family since the 1990s, the focus – especially through successive Malaysia Plans since its sixth iteration (1991-1995) – has been to facilitate female participation in the labour market with less attention paid to changing traditional care roles within the domestic spaces.[40] Thus, while the female labour force participation rate (LFPR) has improved over time, there is still a significant gap with male LPFR, with the latest figure standing at 56.6% for female compared with 83.2% for males.[41]

In addition, Malaysia's female LFPR is marked by regional disparities, with women living in urban areas showing higher participation rates compared with their rural counterparts.[42] Malaysia's latest female LFPR figure is also lower than the International Labour Organisation's current global estimate (60.8%) and a number of its Southeast Asian neighbours, including Thailand (68.3%), Vietnam (75.3%) and Cambodia (78.9%).[43] Despite this, Indonesia's female LFPR is slightly lower than Malaysia's, at 54.8%.

The challenge for Malaysia lies in shifting how the division of care work in the domestic spaces is conceived in society. While policies to improve care provision and labour practices – for example, making childcare more accessible and working arrangements more family friendly – are important to unlock the ability of as many people as possible to participate in the labour market, there must also be efforts to dispel traditional conceptions about gender roles in caregiving to allow for an equitable redistribution of the care burden. Since there are similarities, both in terms of cultural practices and labour-market conditions, Indonesia's experience and strategies should serve as a valuable learning opportunity for Malaysia.

2.6 Conclusion

As Malaysia navigates the many challenges to transform and strengthen its care economy, learning and understanding how others navigate similar hurdles could provide a lot of food for thought. This is true, especially in terms of suitable solutions to accelerate inclusive and sustainable changes to the country's care ecosystem.

This paper analyses three of those challenges – coordination issues between different levels of government and agencies, the double-edged potential of the

professionalisation-commodification nexus and prevailing traditional gender norms. It also juxtaposes them with examples from Brazil, Cuba and Indonesia in dealing with those challenges.

Addressing the coordination issue, the Brazilian example suggests that it is possible to standardise the types of services offered across the different levels of society while allowing for those services to be offered through localised ways. The Cuban example, meanwhile, underscores the importance of maintaining the value of social justice as a hallmark of social care as we embark upon the professional transformation of the care profession. Finally, Indonesia's example highlights the possibility of crafting strategies to challenge longstanding sociocultural norms to change societal expectations of care.

There are, of course, an inexhaustive list of other challenges and cases. This chapter is only a modest attempt at inviting more reflections on such a direction in Malaysia, particularly in terms of drawing examples from less-discussed Global South contexts that have undertaken steps to reform their ecosystems.

3

Local, regional realities in care economy

Urban needs differ vastly from rural areas, rendering one-size-fits-all solutions irrelevant

Teo Sue Ann

3.1 Introduction

Malaysia is a constitutional federation whereby its states and regions share sovereignty with a central federal government. The constitution defines Malaysia's political system and outlines the division of powers as well as responsibilities between the federal and state governments.

States within a federation have a degree of self-governance, allowing them to manage affairs in certain areas, such as education, healthcare and local law enforcement. The division of powers and the status of the states are constitutionally entrenched, which means they cannot be altered unilaterally by either the federal government or states without a constitutional amendment.

This political system underscores policy implementation in Malaysia. Thus, understanding this crucial context is important in advancing the government's interest in the care economy.

Malaysia's care economy is a sector that encompasses all forms of care work – paid and unpaid – that support the wellbeing of individuals and communities. This includes childcare, eldercare, healthcare and other forms of domestic work.[1] Its policy discourse is anchored on the argument that investment in the care economy could lead to significant economic benefits, such as increased employment opportunities, professionalisation of care services and overall gross domestic product (GDP) growth. The wide-ranging nature of care economy as a sector is believed to be both profitable (potentially raising GDP by 10-39%) and capable of stimulating growing demands for healthcare services, both domestically and internationally.[2]

Nonetheless, only a few states or local governments have expressed a similar degree of enthusiasm as the federal-level ministries.[3] Therefore, the question that needs to be answered is how far and widespread is the implementation of federal-level policy initiatives in states' economic development plans.

Despite the insurgent policy discourses and interests to revitalise the care economy, proposed recommendations often suggest that an overarching policy framework would suffice for revitalising care economy. This chapter argues that such an approach, specifically for the care economy, is not only insufficient but falsely assumes Malaysian society as homogenous, with similar needs for care. Current discourses imply that Malaysia's grassroots communities, who are living

in different regions in both urban and rural areas, could benefit equally from the federal government's initiatives and strategies in the care economy.

There is a need to unpack the intricacy of Malaysia's historical, political, social and economic contexts for policy discussion on the care economy. This chapter focuses on two important aspects – the regional administrations and governance in Malaysia as well as the complexity of uneven development in terms of infrastructure, social and economic. This chapter also presents narratives from grassroots communities, whose stories unravel their lived realities and reinforce the pivotal nuances in the policy discussions on Malaysia's care economy.

3.2 Regional and administrative divisions

The colonial history of Peninsular Malaya and the subsequent formation of Malaysia in 1963 remain the mould for Malaysia's federalism as well as a determinant of the regional relationships between the peninsula, Sabah and Sarawak.

Malaya comprised of 14 states and two federal territories after independence. However, negotiations between political leaders that ensued between Singapore, Sabah (previously known as North Borneo) and Sarawak led to the exclusion of Singapore. Subsequently, in 1963, Malaysia was formed, with Sabah and Sarawak signing the Malaysia Agreement of 1963 (MA63).[4]

Among the important conditions was the federal government's promise to grant Sabah and Sarawak significant autonomy regarding immigration, land and local government. This autonomy allows Sabah and Sarawak to manage their own affairs to a greater extent compared with other Malaysian states. For instance, the local governments in both regions can regulate who enters their territories. Sabah and Sarawak also receive additional financial grants and revenue sharing, which give them greater control over their finances. These benefits are crucial for the development of infrastructure and public services.

This historical episode remains a significant juncture in the evolution of the regional relationships between the federal government, Sabah and Sarawak – one that continues to be a reference point in explaining the complex mechanisms of policy implementation in Malaysia, i.e., from the federal to the regional levels.

However, a recent development must be noted. In January 2023, the federal government announced that Malaysia will, henceforth, comprise of 11 states, two regions and three federal territories, as opposed to the previous format of 13 states and three federal territories. Sabah and Sarawak are now considered as two regional divisions instead of states.

Arguably, this shift was made to honour the long overdue condition stated in MA63. As of September 2024, 11 out of 21 claims under MA63 have been resolved, including the handover of regulatory control over gas supply to Sarawak, which is a significant step towards greater autonomy.

Nonetheless, the seemingly overdue formalisation of the regional divisions is not without basis. Discourses about uneven development have been around since MA63 came into being, owing to the political differences between different regions.[5] Indeed, MA63 also calls for the federal government to address the development disparities between the peninsula and the two regions, which encompass the issue of investment in infrastructure, healthcare, and education.

The federal government has also established a technical department under the Public Works Department, which will allow for more localised decision-making and governance. This could lead to more efficient and effective management of local projects and initiatives.

Overall, the resolution of claims under MA63 enhances the autonomy of Sabah and Sarawak, allowing them to have greater control over their resources, administrative matters and financial independence.

The recent resolution of MA63 illuminates further the intricacies of Malaysia's political system, especially when involving policymaking and policy implementation. Due to the intricacies of regional political dynamics, social, cultural and local differences, states and regions might have different ideas and sense of urgency about advancing Malaysia's care economy, as other developmental issues may take priority. Particularly, observers and analysts identify infrastructure development as the more urgent priority for the two regions, which are still focusing on economic growth and playing catch-up with the peninsula.[6]

3.3 Gaps in discourse

There is a need for more nuanced policy discourse of the care economy precisely because of the dynamics of the political system and intricate economic as well as cultural complexities in different regions and territories. This means that revitalising the care economy does not necessarily equate to growing it as a sector if the strategies do not match with local needs and cultural norms.

I. Dynamics of Sabah and Sarawak

The pluralistic societies of Sabah and Sarawak – and the complexities of their local politics, culture and traditions – mean that the approaches for advancing the care economy in these states must also differ from those planned for the peninsula.[7]

For instance, Bumiputera minorities in Sarawak (such as Melanau and Bidayuh) have always had the highest incidence of poverty in the region.[8] Many of these communities live in the interior parts of Sarawak, where policy implementation has often been a challenge.[9] However, existing care economy discourses in Malaysia have not addressed these differences. The issue of affordability is pivotal to ensure the inclusivity of care economy for society. Based on the Department of Statistics Malaysia's data from 2022, Sabah still recorded the highest incidence of poverty (19.7%) in the country, followed by Kelantan (13.2% – the highest incidence of poverty in the peninsula) and Sarawak (10.8%).[10]

The high rate of poverty in these areas indicates two possible consequences. First, the majority in Kelantan, Sabah and Sarawak might not be able to afford care services. Second, this also means that demand for care economy as an industry might not be sustainable in these states.

For example, the town of Kudat in Sabah is one of 12 poorest districts in Malaysia, making poverty eradication one of the district's highest priorities. Households are relatively large but struggling to meet basic needs, such as food. Education, infrastructure and geographical locations have been identified as the major thematic issues faced by the communities in Kudat and Sabah in general.[11]

It is also noteworthy that the need for care, though important, would remain secondary if the town's education level, public infrastructure and healthcare facilities still need substantial improvement. Such deprivation of basic needs means care support is not a priority for residents of Kudat and Sabah in general.

Besides these, a more critical issue is the question of citizenship. A villager interviewed connected the issue of citizenship to the lack of access to healthcare facilities in Sabah:

"Perlu ada klinik ibu dan anak sini… sebab banyak yang masalah dokumentasi sebab tidak mampu ke sana… bersalin dirumah saja." ([We] need clinics for mothers and children here… a lot of people have documentation issues and thus are unable to go there [the health facilities in town]… they give birth at home.)

Hence, when parents face difficulties accessing healthcare facilities because of distance or cost of travelling, they will most likely delay the registration process. If children remain undocumented, they are considered as illegal immigrants and have no legal rights to remain in the country, thus placing them under the constant risk of detention indefinitely. These children will have limited access to education and healthcare, especially those provided by the government. It is also important to note that a mother without citizenship will not be entitled for the government-subsidised healthcare services and must pay the normal cost that could be astronomical. Given that there are more than a million undocumented people residing in Sabah (27.9% of its total population), this also means that more than a quarter of the population lack access to care services provided by the government.[12]

It is worth emphasising that the context of Sabah is not generalisable with the context of Sarawak. Despite the high incidence of poverty, Sarawak's economy is one of the largest contributors to GDP with the service sector being one of the most lucrative.[13] Though the care economy can be a potential industry within the service sector that improves the socioeconomic conditions of Sarawak communities, such a proposal must be matched with the realities on the ground, which are laced with multiple nuances.

For example, Sarawak is one of the five states in Malaysia with a high population of older folk, but high poverty incidence indicates that many of them cannot access care services. Despite being the most profitable sector in Sarawak, studies have also shown that the service sector has been facing challenges, such as low productivity growth, shortage of skilled workforce and weak internet connectivity for communities living in rural areas.[14] These challenges imply that advancing Sarawak's care economy remains difficult.

II. Dynamics of urban and rural strata

The urban-rural divide should also inform Malaysia's care economy discourse. The assumption that the care economy has the same economic potential across all regions of Malaysia, in both urban and rural areas, is simplistic. The challenges to the care economy are compounded by the diverse and multicultural nature of Malaysian society, which paves the way for politically charged differences in identity and locality. There is a need for more diversified approaches and action plans for care economy initiatives based on different local needs and priorities.

This does not imply that current issues, such as an ageing Malaysia and high number of unpaid care work, especially among women, are secondary.[15] Rather, the sustainable development of Malaysia's care economy requires a thorough understanding of local contexts, which could lead to the better crafting of care-related policies. This section offers some of the nuances missing in the current discourse.

For example, ongoing conversation maintains that a revitalised care economy (i.e. high quality, affordable and accessible) could improve the wellbeing and career opportunities of unpaid caregivers, a profession often dominated by women. Although professionalisation might improve the quality of care services, this would potentially increase the cost for the services. Current discourses have yet to explain how professional care service could still be of high quality yet affordable and accessible for those in rural areas.

Urban areas have better infrastructure and more facilities dedicated to care services, such as nursing homes, childcare centres and hospitals.[16] These factors allow for better access to facilities with more trained caregivers and professionals, who could receive higher wages than those working in rural areas.[17]

Moreover, local cultural norms in different regions and strata are distinct because of different lived realities. The desire for career advancement would be different for city dwellers and those in rural areas, which bear consequences for provision of care. Urbanites may pursue formal employment and career advancement more aggressively than rural settlers. The bonds among villagers might also be more closely knitted than residents of apartments or gated communities. The implication is that neighbours in a village could offer childcare support that are more accessible and affordable even if they are not certified professionally.

The concept of the "sandwich generation" might even have different implications for communities in different localities.[18] With the prevailing income disparities between urban and rural communities, the sandwich generation in rural and remote areas might face additional issues of ensuring their parents receive the appropriate healthcare service in a timely manner. There, older people face more pressing issues of access to healthcare, possibly because of poor road conditions or lack of transportation.

In rural areas, the conversation regarding the care economy revolves around limited facilities when residents, in fact, need more comprehensive care services. As indicated in the previous section, rural settlers have limited access to care services because of travel distances and poor road conditions. Meanwhile, the shortage of trained and professional caregivers in rural areas means there are fewer job opportunities and lower wages, in general, thus imposing further challenges for the care economy to flourish.[19]

III. Dynamics of disparities among states

Even if we ignore the urban-rural divide, discrepancies could still be observed in the lived realities of the population in different states in the peninsula. For example, as with Sabah and Sarawak, Kelantan also has a high incidence of poverty, including and especially in urban areas. Although the state economy is diverse, including agriculture, manufacturing and tourism, its population is often forced to choose between caregiving and work. This could explain why there are many Kelantanese women who drop out of the labour force. However, just like in Sabah and Sarawak, women tasked with caregiving are also juggling between caregiving and mitigating misfortunes, such as constant flooding and a lack of treated water.

One single mother interviewed described it as such:

"Rantau Panjang ni tiap-tiap tahun wajib tenggelam. Cuma sedikit atau banyak yang tenggelam. Tahun ni banyak." (It floods here in Rantau Panjang every year. It is just a matter of frequency. This year, it has flooded a lot.)

Such a response demonstrates why one-size-fits-all strategies in the care economy might not be beneficial without factoring in Malaysia's diverse ground realities. Flood is a persistent and longstanding problem in Kelantan – the most recent floods in 2024 affected more than 8,000 people.[20] In Rantau Panjang, where the respondent resides, the floods almost paralysed the town with the main routes submerged in water.

Therefore, it is possible that many residents of Rantau Panjang, Kota Baru, Pasir Mas, Tumpat, Bachok, Tanah Merah, Pasir Puteh, Kuala Krai, Machang and Jeli do not perceive caregiving as urgent or important as the need to obtain basic needs for their daily lives. Anticipating floods and securing a continuous supply of clean water, thus, becomes their top priority, with many of them relying on a boring well system or assistance from local politicians.[21]

3.4 Conclusion

The arguments in this chapter do not dispute the importance of the care economy as a potential and profitable economic sector. However, existing strategies and initiatives would be rendered irrelevant if policymakers do not consider prevailing gaps and nuances present at the different administrative levels. There is an imperative to consider carefully regional dynamics and disparities among states and localities in the care economy discourse. This will then ensure a comprehensive revitalisation of the care economy in an inclusive manner, one that does not leave anyone behind.

4

On CBR rehab centres' challenges

Staff ratio, poor pay, inadequate infrastructure among difficulties

Lydia Ann Bill
Sapura Arshad
Mohd Fouzi Mohd Isa

4.1 Introduction

The care economy is the cornerstone of a compassionate and inclusive society. It places significant importance on empowering persons with disabilities (PWDs) and supporting institutions that serve them, such as pertubuhan pemulihan dalam komuniti (community-based rehabilitation – PPDK) centres. By focusing on the unique needs of these individuals, the care economy underscores a commitment to the idea that every person deserves the opportunity to lead a fulfilling life.

This chapter explores the challenges PPDK face in Malaysia, ranging from administrative hurdles and resource constraints to the professionalisation of care-givers and need for standardised social work education. Additionally, it addresses the struggles encountered by PPDK centres in Sabah and Sarawak, particularly their remote locations and limited workforce to support operations.

The concept of PPDK traces its roots to the community-based rehabilitation (CBR) model introduced by the World Health Organisation (WHO) in the 1980s. WHO viewed rehabilitation for PWDs as a complex subject requiring broad and expensive resources. Such rehabilitation practices are frequently concentrated in medical institutes where specialists offer care services. In reality, this format has hindered access for many people requiring such services, particularly those from the low-income groups or living in rural areas.

Recognising this gap, WHO shifted its approach from rehabilitation treatment centres to community-based services. This transition signalled the start of a new policy aimed at empowering local communities to help PWDs. In the 1980s, WHO launched the CBR guidelines to improve access to rehabilitation services for people with disabilities, particularly in low- and middle-income countries.[1]

By utilising sufficiently trained local human resources and establishing effective referral systems, WHO envisioned better access to rehabilitation services. This community-based model enabled people with disabilities to participate more fully in social and economic activities, enhancing inclusion and improved quality of life.

As of 2023, Malaysia's Department of Welfare (Jabatan Kebajikan Masyarakat – JKM) had 736,607 registered PWDs.[2] Among these, the top three categories of disabilities are learning (254,503), physical challenges (265,221) and visual impairments (63,779), highlighting the diverse needs within the PWD

community and the importance of tailored support services. This also means that a greater fraction of the population requires caregiving services, which could place significant financial burdens on households, the economy and the government.

Headed by the Ministry of Women, Family and Community Development (MWFCD) through JKM, Malaysia's rehabilitation programme offers three primary types of services to people with disabilities across Malaysia: home-based, centre-based and central home-based care.

Home-based services involve providing rehabilitation and support in an individual's home. This approach is particularly beneficial for individuals unable to travel to a centre because of mobility issues, severe disabilities or living in remote areas.

Meanwhile, centre-based services are offered at dedicated PPDK, where people with disabilities can receive various therapies, skills training and support in a structured environment. As mentioned earlier, PPDK is modelled after the CBR programme, established with the aspiration of WHO's community-centric-development approach to foster social inclusion and community support to help the disabled.

On the other hand, the central home-based services combine elements of both home and centre-based care, offering flexibility to individuals who may require home visits but also benefit from accessing specific services or facilities available at PPDK.

According to JKM, there are a total of 574 PPDK across Malaysia. The budget allocated for PPDK is also increasing each year, from RM91 million in 2019 to RM133.5 million in 2024, an increase of RM42.5 million in the span of five years.[3] Data from Table 4.1.2 reveal a notable similarity between the number of trainees registered in PPDK and the overall population of PWDs in the country, indicating the extensive reach of these centres in addressing the needs of this demographic.

It can be observed that a majority of trainees (pelatih) in PPDK are categorised as having learning disabilities, followed by the physically challenged. Therefore, PPDK are pivotal in providing targeted services to the most common disability categories, showcasing their role as an essential component of the care economy.

There was a recent announcement to increase trainees' allowance from RM150 to RM300. Workers and supervisors are also slated to enjoy higher allowances. This suggests that the government is open and concerned about the wellbeing of workers servicing PWDs.

Table 4.1.1 Number of PPDK, according to states and regions (2023)

States/regions	Number
Perlis	10
Perak	42
Penang	26
Kedah	43
Pahang	53
Terengganu	47
Kelantan	45
Selangor	61
WP Kuala Lumpur	10
WP Putrajaya	4
WP Labuan	2
Johor	73
Melaka	19
Negeri Sembilan	44
Sabah	40
Sarawak	55
Total	574

Source: JKM

Table 4.1.2 Number of trainees at PPDK by state and category, 2023

State	Category							
	Visually impaired	Hearing	Physical	Learning disabilities	Speech	Mental	Multiple	Total
Johor	17	49	238	1,717	7	15	198	2,241
Kedah	5	30	146	1,176	7	5	176	1,545
Kelantan	7	19	123	984	4	3	107	1,247
Melaka	3	7	45	330	2	2	28	417
Negeri Sembilan	5	25	72	874	4	5	132	1,117
Pahang	14	23	123	841	10	7	101	1,119
Perak	9	29	108	701	5	7	86	945
Perlis	8	6	58	287	5	3	32	399
Penang	11	18	84	760	1	7	65	946
Sabah	48	96	392	1,844	32	22	259	2,693
Sarawak	23	71	251	1,326	15	13	111	1,810
Selangor	13	27	256	1,927	6	18	197	2,444
Terengganu	14	46	223	1,305	4	5	213	1,810
WP Kuala Lumpur	31	13	35	311	1	4	30	425
WP Labuan	0	2	6	46	0	0	2	56
WP Putrajaya	0	0	29	96	0	0	10	135
Total	208	461	2,189	14,525	103	116	1,747	19,349

Source: JKM

However, it also raises questions about whether PPDK have sufficient resources, staffing and expertise to address the needs of large trainee populations. This issue points to the necessity of ongoing investment in PPDK to ensure that they remain equipped to meet the growing and diverse needs of the PWD community.

Since 2018, the government has mandated that all PPDK in Malaysia register with the Registrar of Societies (RoS). Previously, these centres were registered under Jabatan Pembangunan Orang Kurang Upaya (Department of Development of Persons with Disabilities), an office under JKM.[4]

Following this shift, PPDK must now comply with RoS requirements, which involve a distinct set of standards and regulatory obligations compared to their former registration under JKM. It has also introduced new administrative burdens and increased human resource requirements for newly registered PPDK, posing challenges for some centres across Malaysia.

For instance, Sarawak's minister of women, early childhood and community wellbeing development has advocated for more flexibility in RoS registration for the state's PPDK, highlighting that not all centres are equipped to meet the requirements.[4] Centres that cannot comply with these regulations risk closure – a situation that could severely impact on the provision of essential services for vulnerable communities in Sarawak. This challenge undermines efforts to support the wellbeing and inclusion of people with disabilities, particularly in rural areas where PPDK may already face resource constraints.

Thus, despite the community-centric concept of PPDK and budget increment, challenges remain for PPDK. The 2018 mandate to register with RoS brought about both new administrative and financial challenges to PPDK. This chapter seeks to understand the major deprivation that PPDK face and suggest ways to improve the livelihood of caregivers as well as people with disabilities to ensure that no one is left behind.

4.2 Methodology

During the research process, the authors employed desktop research of available data from 2023 and 2024 gathered by the All-Party Parliamentary Group Malaysia-Sustainable Development Goals (APPGM-SDG).

The discussion here focuses on the peninsula's districts, including Pontian (Johor), Sungai Petani (Kedah), Pagoh (Johor) and Sarawak district Sibuti. Additionally, qualitative insights were gathered through discussions and interviews with supervisors from PPDK Sungai Buloh and PPDK Kuala Klawang. These

districts were chosen to represent a diverse range of socioeconomic settings, encompassing suburban, rural and remote populations, providing a balanced perspective on PPDK's challenges and opportunities.

APPGM-SDG conducted focus-group discussions (FGDs) to collect data and acquire insights into community members' viewpoints, experiences and perceptions. On average, 10 FGDs were held in each district over three days, with participants from a variety of backgrounds, positions and roles in society, enabling the collection of a wide spectrum of viewpoints on the communities' difficulties. The data were then examined by identifying repeating themes, emerging issues and contextual nuances connected to socioeconomic challenges experienced by PPDK.

Meanwhile, semi-structured interviews were also conducted with supervisors from PPDK Sungai Buloh and PPDK Kuala Klawang. They were selected as key informants because of their direct involvement in managing operations, supporting trainees and addressing challenges within the centres. This method provided qualitative, first-hand perspectives, enriching the study with practical knowledge and real-world examples.

4.3 Discussion

Challenges faced by PPDK consist of systemic issues. Some of these require more than just government intervention – multi-stakeholder support is needed to uphold the sustainability of PPDK.

To understand how to move forward, this section will discuss the challenges.

I. Staffing constraints: challenges in maintaining 1:5 ratio

In 2013, JKM's guidelines recommended a ratio of 1:5 staff member to trainees to ensure the personalised care and effective supervision of individuals with disabilities.[5] However, some PPDK face challenges in meeting this standard because of staffing and resource constraints. The limited availability of trained personnel and budgetary constraints often lead to an understaffed workforce, resulting in higher workloads for existing staff and potentially reduced quality of services.

Table 4.3.1 Staff-trainee ratio in PPDK centres across states, 2023

State	Workers*	Trainees		Total	Ratio of staff to trainees
		Centre	Home		
Johor	412	1,793	448	2,241	1:4
Kedah	265	1,281	264	1,545	1:5
Kelantan	211	996	251	1,247	1:5
Melaka	110	351	66	417	1:3
Negeri Sembilan	238	902	215	1,117	1:4
Pahang	239	906	213	1,119	1:4
Perak	164	748	197	945	1:5
Perlis	75	320	79	399	1:4
Penang	230	829	117	946	1:4
Sabah	270	2,112	581	2,693	**1:8**
Sarawak	340	1,536	274	1,810	1:5
Selangor	421	2,245	199	2,444	1:5
Terengganu	265	1,291	519	1,810	1:5
WP Kuala Lumpur	67	378	47	425	**1:6**
WP Labuan	12	48	8	56	1:4
WP Putrajaya	35	119	16	135	1:3

Source: JKM

*Number of workers is the total number of supervisors and workers.[6]

Based on Table 4.3.1, the ratio of workers to trainees is calculated using only the number of trainees at the centre, excluding those in home-based programmes. This also means that workers stationed at the centre are primarily responsible for providing care to a maximum of five trainees at one time. This concept aligns with the statement by the deputy WFCD minister during a special chamber session in the 15th Parliament, where it was clarified that the

1:5 ratio signifies that one worker could cater to no more than five trainees simultaneously.

Nevertheless, the table reveals that not all states adhered to the recommended staff-to-trainee ratio. Some states, such as Sabah and Kuala Lumpur, have a higher number of trainees compared with the recommended number of workers. This indicates that PPDK in these states are operating with an increased number of trainees per worker, exceeding the optimal 1:5 ratio. The discrepancy highlights the challenges faced by PPDK in managing their resources effectively, potentially impacting on the quality of care and supervision provided to trainees.

Another point is that while PPDK in some states (e.g. Kedah, Johor and Perak) may appear to conform to the prescribed 1:5 ratio, findings from the AP-PGM-SDG issue mapping and comment from members of parliament (MPs) suggest that certain PPDK in these areas have more than five trainees under the supervision of a single worker. This implies that although the statistics show compliance with the recommended ratio in most states, a more detailed, micro-level analysis reveals a different reality on the ground.

To illustrate, a worker at PPDK Pontian reported that:

"Satu petugas jaga sampai sembilan pelatih… Sepatutnya, autism hyper tu satu orang satu. Satu pelatih satu petugas. Itu yang kadang-kadang kita bagikan time one to one dengan yang lain. Penat." (One worker is responsible for nine trainees… One hyperactive autism child should be handled by a single worker. But we will have to share our attention with other children. It is tiring.)

This ratio was also brought to the attention of MPs in the special chamber during the 15th Parliament. The Bakri MP stated:

"Penetapan nisbah yang tidak sesuai ini telah mengakibatkan pengurangan jumlah petugas yang diperlukan serta membebankan petugas dan penyelia dengan tugas yang lebih berat." (The application of this disproportionate ratio has resulted in a reduction in the number of workers required while also adding to the burden of officers and supervisors.)

Therefore, while the recommended 1:5 staff-to-trainee ratio for PPDK is a crucial standard for ensuring quality care and supervision, the analysis reveals that some PPDK across Malaysia face challenges in maintaining this ideal ratio. Although certain states – such as Kedah, Johor and Perak – appear to meet the prescribed ratio, data on the ground suggest that some centres are understaffed and unable to provide optimal care.

II. Scarcity of professional services

The lack of professional services, such as physiotherapists, doctors or nurses in PPDK, affects significantly the quality of care provided to people with disabilities. These professionals are essential for providing specialised treatment, rehabilitation and healthcare services, which are often beyond the expertise of volunteer caregivers.

While physiotherapy sessions can be conducted by PPDK workers or supervisors, it should be noted that they are volunteers with little professional background.[7] In practice, they only take courses or training once a year and are unable to meet the needs of the disabled.

The presence of health experts, such as physiotherapists and occupational therapists, is also limited to once a month or two. Their visit is usually limited to monitoring and evaluating the overall development of PWDs rather than administering treatment.

This situation was again brought up during the aforementioned 15th Parliament's third-term debates in March 2024, where the Bakri MP stated there is a lack of specialist doctors, physiotherapists and special education teachers, reflecting a growing challenge as the demand for special needs services continues to rise.[8] To illustrate this, in Johor Bahru, for example, there is only one specialist who can diagnose children with special needs and the wait time for an appointment with this specialist can take up to six months.

Without sufficient access to skilled professionals, such as therapists, social workers and specialised trainers, PPDK struggle to offer comprehensive rehabilitation services that meet the diverse needs of their trainees. This lack of professional support not only reduces the effectiveness of the programmes but also hinders efforts to raise awareness and encourage families and communities to engage with the centres.

For instance, both PPDK Sungai Buloh and PPDK Kuala Klawang face challenges in raising community awareness about their rehabilitation services. This problem is compounded by the scarcity of professional therapists, which could otherwise serve as a draw for families seeking specialised support for their loved ones. Without effective outreach and sufficient resources, these centres might struggle to fulfil their role as vital community hubs for rehabilitation and care.

III. Insufficient allowances

Workers and trainees in PPDK are typically underpaid. This issue of insufficient allowance was raised during the 15th Parliament's third-term debates in July 2024, where the Bakri MP once again highlighted concerns that the current allowances

do not reflect adequately the work and responsibilities involved in caring for PWDs.[9]

Although the allowances for workers were increased from RM800 to RM1,200 in 2021, while supervisors received an increment from RM1,200 to RM1,500 during the same period, these adjustments still fall short of fair compensation. It was additionally pointed out that workers and supervisors have had to wait 10 to 15 years for an increase in their allowances, calling into doubt the current system's ability to meet economic demands and recognise their achievements.

The APPGM-SDG issue mapping reports in Sungai Petani also highlight that since the roles of supervisors and workers in PPDK are classified as "voluntary", they are unable to demand higher allowances or negotiate better salaries. This limitation further underscores the inadequacy of the current allowance structure as compensation.

In addition, although PPDK workers and supervisors are included in retirement saving schemes and social security systems, such as Employees' Provident Fund (EPF) and Social Security Organisation (Socso), their remaining take-home allowance is still small. A respondent from PPDK Sungai Petani stated:[10]

"Sekarang taraf kami RM1,200. Tapi bila dipotong EPF, Socso, kami hanya dapat RM1,083. Kami sebagai sukarelawan. Lebih bagus kalau kita boleh fight untuk dapatkan status dari sukarelawan kepada kontrak." (Now our allowance is RM1,200. But when deducted for EPF and Socso, we only get RM1,083. We are volunteers. It would be nice if we could fight to switch our status from volunteer to contract workers.)

The status of PPDK workers in Malaysia, where they are classified as volunteers rather than contract employees, poses various issues, particularly financial stability and access to services, such as bank loans. A worker in PPDK Pagoh stressed a concern regarding status:[11]

"Status tidak termasuk dalam bawah akta pekerjaan. Disebabkan status sukarelawan. Slip gaji, bank tidak pandang. Sebab kita dalam tiket sukarelawan." ([PPDK workers'] status are not covered by the Employment Act because they are volunteers. The bank does not recognise the payslip, because we are considered volunteers.)

PPDK Kuala Klawang and PPDK Sungai Buloh also echoed the sentiments that the allowance provided to staff is inadequate, particularly given the growing demands and rising cost of living. Despite their roles being categorised as volunteer-based by the government, the staff in PPDK face responsibilities that are equivalent to full-time professional caregiving and rehabilitation work. This mismatch between their contributions and financial support creates challenges in maintaining staff motivation and retention.[12]

Without paycheques or established employment status, PPDK workers might struggle to convince banking institutions of their ability to repay loans.

This creates a big barrier for those who need to buy homes, vehicles or other large assets. Moreover, allowances or stipends from PPDK are deemed "informal" income and might not meet the criteria established by banks and other lenders.

Without the ability to build a strong credit history, PPDK workers are left without financial flexibility. Overall, this systemic challenge directly impacts on the livelihood of both PPDK workers and supervisors.

IV. Inadequate physical space and infrastructure

The existing infrastructure in many PPDK centres, particularly in rural and underserved areas, is often insufficient to accommodate the specific requirements of people with various physical, mental and developmental disabilities. This problem can be divided into two primary issues.

First, many PPDK programmes are housed in ageing buildings that require frequent maintenance and upgrades to remain functional. Over time, these facilities may face structural issues, such as leaking roofs, damaged floors or outdated electrical systems, all of which pose challenges of providing safe and effective services.

This is evident, especially in rural Sabah and Sarawak, where most PPDK are located far from the city. Many PPDK centres in rural areas, particularly in Sabah and Sarawak, face serious maintenance issues, which severely impact on the quality and safety of the facilities.

An example of such inadequate infrastructure is PPDK Sibuti, where the centre is housed in a wooden structure.[13] This type of infrastructure presents various safety hazards, including structural instability due to wear and tear, risk of fire and termite infestation, among others. With poor road networks and difficult access, the challenges of upgrading and maintaining PPDK become even more severe. Such centres are often left in a dilapidated state, with limited resources for repairs or renovations.

Additionally, the lack of room partitions in many PPDK poses a functional challenge, especially when working with children with special needs, such as those with autism or attention deficit hyperactivity disorder (ADHD). An informant from PPDK Kuala Klawang affirmed the issue, explaining further that these children often have specific sensory and behavioural needs that require environments designed for focused and individualised attention.

A dedicated physical space is important for children with autism because it affects behaviour, sleeping patterns and stress.[14] This was also found in the FGD conducted in Pontian and Pagoh, where supervisors discussed that autistic or ADHD children need a separate room from their peers because they are stimulated differently by their environment, which may lead to tantrums.

Second, many PPDK lack the specialised equipment required to meet the diverse needs of PWDs. This includes mobility aids (such as wheelchairs, walkers and crutches) as well as rehabilitation equipment for physical therapy and other services.

A participant from the FGD in PPDK Pontian reported:[15]

"Peruntukan bilik fisioterapi, tetapi kami kekurangan. Kami juga kekurangan peralatan yang baru untuk kegunaan pelatih kami. Juga bilik pemulihan." (Funding for a physiotherapy room and a rehabilitation room is limited. We also lack the equipment and space needed to treat the trainees.)

In some cases, the lack of sufficient and appropriate infrastructures for PPDK centres have forced them to operate in rented spaces. This limits the ability to make necessary modifications to accommodate the needs of PWDs. These rental properties often lack essential features, such as accessible layouts, sufficient space for rehabilitation activities or proper facilities for caregivers and trainees.[16]

"Kami memerlukan satu tempat yang selesa, sini rumah sewa, rumah sewa faham jelah. Tak boleh tambah-tambah... Perlu tempat selesa yang bersesuaian sebab budak besar ada." (We need a comfortable space. This is a rented house and you know how it is with rental properties – we cannot modify the layout. But we really need a proper space because we also have older children.)

Hence, the absence of purpose-built or adequately equipped facilities affects the quality of services and overall comfort of both trainees and staff, highlighting the urgent need for investment in dedicated, accessible infrastructure for PPDK.

V. Limited access to professional benefits, development courses and training

Since PPDK workers in Malaysia are often classified as volunteers, they do not enjoy the same benefits as regular employees, such as paid time off for attending training or courses. This lack of benefits is a significant challenge, especially given that workers are frequently expected to upgrade their skills through professional development programmes.

According to the deputy WFCD minister during the 15th parliamentary debate, JKM had organised courses that would empower workers and supervisors of PPDK in their capacity building.[17]

From 2009 to 2023, a total of 1,838 supervisors and workers attended kursus asas petugas PPDK (basic PPDK workers' course). They received an appreciation token from JKM in the form of sponsorship for the course Sijil Kemahiran Malaysia Tahap 3 – Operasi Pemulihan Dalam Komuniti (Malaysian Skills Certificate Level 3 – Rehabilitation Operations in the Community).[18]

However, despite such support from the government, there are still gaps in capacity building for PPDK workers. As discussed by an MP:

"Petugas PPDK berdepan dengan masalah kekurangan kursus asas professional yang menyeluruh dan ini juga menyebabkan mereka kerap kali berhadapan dengan tugas-tugas penting tanpa pengetahuan profesional yang diperlukan." (PPDK workers are faced with thelack of comprehensive professional basic courses and this causes them to undertake significant work without necessary professional guidance.)[19]

Thus, training equips workers with the skills and knowledge to address the diverse needs of PWDs effectively. This professional development not only improves the quality of care and rehabilitation services but also fosters a sense of competence and purpose among staff. When workers feel adequately prepared and valued, their job satisfaction and motivation increase, leading to a more positive work environment.[20]

VI. Sabah and Sarawak's challenges

While the previous sections explore the challenges faced by PPDK in the peninsula, there is also an imperative to acknowledge the special challenges faced by PPDK in Sabah and Sarawak. The differences emerge from unique regional factors, such as geographical and infrastructure barriers, economic disparities, governance, and policy implementation.

Referring to Table 4.3.1, Sabah's worker-to-trainee ratio in PPDK stands at 1:8, significantly deviating from the recommended 1:5 ratio. This highlights a considerable disparity and underscores the strain on available staff to provide adequate care and support to the trainees. Moreover, it also puts immense pressure on the workers, potentially leading to burnout and affecting their ability to maintain the quality of services they provide.

This issue is compounded by the geographical and infrastructural challenges in Sabah, where many PPDK are situated in rural and remote areas, further limiting access to qualified staff and resources. On top of that, the rural areas of Sabah feature more remote, rugged terrain – including mountains, rivers and dense forests – which makes it difficult and costly to transport building materials and personnel. This drives up the cost of maintaining and improving infrastructure. Therefore, limited access to skilled labour and high expenses in remote regions complicate efforts to maintain PPDKs.

In addition, parents from rural Sabah found that the frequency of long journeys to healthcare services (including PPDK), transit frequency and disruptions constitute the reasons they find it difficult to get quality treatment and rehabilitation services for their children.[21]

As an illustration, a mother from the district of Sipitang, Sabah, travelled 40km every day just so her child with speech delay could get treatment at a PPDK.[22]

Like Sabah, Sarawak also has geographical challenges, which make it difficult to provide consistent services to PWDs. The large, mountainous terrains, limited road access and dispersed communities there make it harder to reach PPDK and deliver services or building materials to all PPDK in need of care.

A site visit to Sibuti, Sarawak, in 2024 revealed that the PPDK there was experiencing major infrastructure issues, which could have a negative influence on the quality of care and services offered. The building's poor condition (broken roof), its wooden structure and lack of maintenance pose safety risks to both caretakers and individuals who rely on the centre for rehabilitation.

On top of that, even though the concept of PPDK is highly encouraged across Malaysia, there are only 55 PPDK in Sarawak (Malaysia's largest state) in comparison to the entire peninsula, which houses 11 states. This means that the whole of Sabah and Sarawak has fewer PPDK centres than the peninsula.

This also shows that the lack of infrastructure hinders their opportunities for growth, inclusion and development. This should not be the case because it is crucial to move beyond viewing PWDs solely through the lens of their disabilities. They, too, may possess immense potential and untapped talent that could contribute significantly to the nation. Additionally, we should not ignore the opportunity that might transpire from this, as evidenced by the region's success in developing world-class athletes.

Sarawak, in particular, has produced exceptional talents, with three Sarawakians – Nicodemus Manggoi Moses, Bonnie Bunyau Gustin and Jong Yee Khie – representing Malaysia in the 2024 Paralympics in Paris.[23] Bonnie Bunyau won Malaysia's first gold medal in powerlifting at the 2020 Tokyo Paralympics and beat his own world record at the 2024 Paralympics, bringing home another gold medal.[24]

Therefore, investing in PPDK holds tremendous promise and when provided with the right ecosystem and pipeline, PWDs in Malaysia could flourish just as well as other people. Expanding PPDK facilities and opportunities would not only enhance sports development but also improve resources for rehabilitation, empowerment and social integration, benefiting both aspiring athletes and the broader PPDK community.

Hence, the combination of geographical hurdles, limited workforce and infrastructural challenges in Sabah and Sarawak call for greater attention from multiple stakeholders. PWDs in the two states have proven that they can flourish and excel in unique ways, with the right support and ecosystem.

4.4 Recommendations

I. Multi-stakeholder collaboration

Improving PPDK in Malaysia offers a range of benefits for both the centres and private companies. By engaging in partnerships, the private sector could address gaps in funding, infrastructure and service provisions at PPDK centres, while enhancing their corporate social responsibility (CSR) efforts. Private companies can allocate a portion of their CSR budget to fund essential repairs, upgrades and operational costs of PPDK, addressing infrastructure issues like those in Sibuti. This support could ensure that the facilities remain safe and functional for caregivers and clients.

In addition, companies can provide training programmes for PPDK staff, helping them acquire new skills or certifications. This strengthens the ability of caregivers to deliver higher-quality care and rehabilitation services, improving outcomes for individuals with disabilities. For example, Columbia Asia Hospital ran a CSR project that provided food essentials and other necessities to support the operations of PPDK Klang Utara's welfare home.[25]

CSR projects often involve the wider community, creating a sense of shared responsibility and pride. By involving residents in PPDK-related activities or events, the community can feel more connected and invested in the centre's success.

II. Fostering social entrepreneurship

Another measure to uplift PPDK is fostering social entrepreneurship within PPDKs. This can be a powerful way to promote self-sustainability, while also empowering individuals with disabilities and their caregivers. PPDK can help develop small businesses where participants produce handicrafts, traditional foods or other local products. These items can be sold in local markets or online, generating income for the centre and providing vocational training for people with disabilities.

Fieldwork conducted by researchers from the APPGM-SDG revealed that PPDK Pagoh started a small chilli farm to increase its financial standing. Such additional activities offer a sense of purpose and independence for the PPDK centre as well as the PWDs it caters to. It also motivates caregivers, as they can see the positive impact of their work and efforts directly, leading to increased job satisfaction.

By adopting strategies such as these, PPDK can become more self-sustaining while also providing valuable life skills and economic opportunities to the individuals they serve.

III. Recognition and industrial placement

While many graduates from fields like psychology, occupational therapy and healthcare can make valuable contributions to PPDK, graduates with a social work degree should be given more attention as their roles are more involved in handling and supporting the disabled communities. They are equipped to handle the complex social, emotional and advocacy needs of people with disabilities, making them ideally suited to PPDK's mission of inclusive, community-centred rehabilitation.

Currently, data on the precise number of social workers in Malaysia are limited. However, a 2019 study by the Malaysian Administrative Modernisation and Management Planning Unit estimated a social worker-to-population ratio of 1:8,576.[26] This figure highlights a significant gap when compared with other developed nations, such as the United States (where the ratio is about 1:490) and Singapore (1:3,448).

The relatively low number of social workers in Malaysia underscores an urgent need to prioritise social work graduates within PPDK. Therefore, integrating university students graduating in social work into Malaysia's PPDK programme as part of an internship or a training programme should be considered. These placements would offer students hands-on experience in working with PWDs, enhancing their practical skills and understanding of community-based inclusive development.

IV. Improving curriculum

Linked to the above is the need to review and enhance the curriculum and modules offered in social work programmes. A study indicates that while six public universities in Malaysia currently offer social work courses, the content and structure of these programmes lack standardisation.[27] This inconsistency limits the uniformity and quality of social work training nationwide.

Moreover, opportunities for social work students to pursue advanced studies at the postgraduate level or to embark on specialisation programmes (such as disability services) are limited. While students in social work programmes demonstrate a solid understanding of working with disabled communities and are generally proficient in both theoretical knowledge and practical skills, there

is still a lack of standardisation and uniformity across programmes at different universities.[28]

This variation in curricula means that graduates may enter the field with differing levels of competency, depending on the institution from which they graduate. Consequently, it is vital to standardise social work education across universities where it would not only benefit students but also enhance the credibility and effectiveness of social work as a profession. Ultimately, this may lead to more comprehensive and high-quality services for vulnerable populations.

Enhanced postgraduate pathways and specialised training options would also support the development of a highly skilled workforce that can meet the diverse and evolving needs of communities.

V. Professionalising roles

The next recommendation is to professionalise roles within PPDK to ensure job stability, recognition and financial security for caregivers and social workers. Social workers in PPDK provide critical services, such as providing emotional and social support, empowering PWDs and their caregivers, and connecting the community with health services. Given these vital contributions, social workers deserve public recognition, supported by licensing as well as regulatory frameworks to uphold standards and formally establish their profession.

Professionalisation also involves equipping social workers in PPDK with skills and knowledge, as they are practitioners working with vulnerable communities. This calls for greater access to training programmes, opportunities for specialisation and continuous upskilling to improve their competencies as well as adapt to the evolving needs of the communities they serve.

Furthermore, social work generally lacks the prestige and remuneration partly because of limited public awareness of the responsibilities that social workers shoulder. Informants from PPDK Sungai Buloh and PPDK Kuala Klawang admitted that the lack of recognition could even impact on their financial stability. This is also evidenced by challenges faced in securing loans from financial institutions, as discussed above.

To address this, efforts must be undertaken to professionalise the workforce, such as introducing workers to certification programmes and facilitating upskilling programmes. Such certifications can elevate their professional status, enhance job prospects and boost their motivation and commitment to the development of PPDK. It is also noted that as caregivers increase their knowledge and confidence in their roles, their wellbeing improves, highlighting the importance of professionalising and investing in the skills of PPDK workers.[29]

4.5 Conclusion

As community-based rehabilitation centres, PPDK play a crucial role supporting PWDs, offering essential services that can improve their quality of life. However, without addressing both structural and workforce-related challenges, their effectiveness remains limited.

As mentioned above, insufficient allowances for workers and supervisors, the scarce number of professionals, an inadequate physical environment, limited access to professional development courses and the unique challenges in Sabah and Sarawak are key issues affecting the processes and agenda of PPDK in Malaysia.

This paper offers some potential remedies to these challenges. First, these can be addressed by engaging private companies to focus their CSR projects on PPDK. While the centres would receive financial assistance, the local communities will also benefit from a strengthened sense of solidarity.

Second, PPDK should be more creative in exploring the potential of social enterprises. The centres can not only reduce their dependence on external funding but also create an environment where PWDs can contribute actively to the community and gain some degree of financial independence.

Third, the government should consider introducing PPDK to universities and enhancing the curriculum of social work programmes. Building on this talent pipeline helps to professionalise the workforce and build a stronger PPDK system. With formal employment contracts and recognised skills, PPDK can attract more skilled workers, thereby increasing the quality of rehabilitation services.

By tackling these issues holistically, PPDK can become more self-sustaining, offer higher-quality services and empower their caregivers and beneficiaries alike. This strategy ensures that PPDK can continue to fulfil their mission of providing essential care and support to PWDs, while contributing to broader community development, self-independence and economic empowerment.

5

Long-term care in ageing society

Aim is to alleviate fiscal strains while fostering more equitable, intergenerational economy

Rahimah Ibrahim
Chai Sen Tyng

5.1 Introduction

Malaysia is undergoing a significant demographic shift as its population ages. Birth rates are falling steadily across all ethnic groups and rising life expectancy have contributed to a rapidly ageing society. In addition, interstate migration patterns are affecting the age-sex structure of urban and rural populations. In recent years, the population growth rate in Malaysia has slowed to about 1% annually, with huge ramifications for the dependency ratio as well as demands for potential care and support.

This chapter explores an estimation for the adult care-dependent population and examines the impact of population ageing on long-term care. We assess current provisions on care for older persons and the national situation of aged care, both residential and non-residential. These include discussions and recommendations on cross-cutting issues and challenges towards a sustainable care economy.

This chapter aims to demonstrate how demographic and economic forces are fuelling the expansion of the care economy for older persons in Malaysia, along with the complexities and implications involved because of an increasing commodification of care.

5.2 Population ageing in Malaysia
Brief overview

In the simplest of terms, population ageing refers to the increase in number and percentage of older persons in a geographical area or location. The chronological ages of 60 or 65 are typically used and, in Malaysia, an older person or "warga emas" is someone 60 years and above.[1] Demographers use a variety of indicators or cut-offs to measure the speed or scale of population ageing but many of the underlying assumptions are less straightforward than they appear.[2]

An "ageing society" is when is generally defined as a nation where 7% or more of the population is aged 65 and above; an "aged society" is when it reach-

es 14% or more, and; a "super-aged society" is when it surpasses 20% or 21%. While these milestones are useful for illustrative purposes, their arbitrary nature provides little practical insight into the actual needs, demand and supply of eldercare services.

Nevertheless, it is evident that Malaysia is experiencing rapid population ageing driven by declining birth rates and increasing longevity, raising concerns that the country is growing old before getting rich. The total fertility rate, an estimation of the average number of children that a woman would have during her childbearing years (15 - 49), has fallen from 4.9 in 1970 to 1.7 in 2020.[3]

In tandem, the average household size has shrunk from 5.5 people in 1970 to 3.9 in 2020.[4] Life expectancy at birth improved from 61.6 years for males and 65.6 years for females in 1970 to 72.6 and 77.6 in 2020.[5] Life expectancy at 60 was 18.2 for males and 20.9 years for females respectively in 2020.[6] This means that half of the hypothetical cohort is expected to survive beyond these estimates. Fertility, mortality and migration are fundamental determinants of population ageing, and current trends underscore the ongoing demographic transformation.

As shown in Table 5.2.1, the proportion of older persons in Malaysia nearly doubled from 5.5% in 1980 to 10.3% in 2020. Over the past four decades, some states have experienced a remarkable shift in the number and percentage of older persons. While Perak remained the "oldest" state in Malaysia, the number of older persons in Selangor grew almost tenfold to 714,400 during the same period. Considering that 21.4% or one-fifth of the total older population in Malaysia lives in Selangor, this puts considerable strain on long-term care (LTC) demands in the state. Kuala Lumpur maintained the highest median age on record at 33.6 years in 2020, meaning that its population size was equally divided into two parts at that midpoint figure.

In Malaysia, ethnic differences significantly influence population ageing trends. The Chinese population is ageing much faster (13.8%) than the Indian population (11.3%) as well as the Malay and Bumiputera communities (9.7%) due to their lower fertility rates and higher life expectancy. Out of the 3.34 million older persons aged 60 or over in 2020, 1.99 million were Malays and Bumiputeras, followed by Chinese (0.95 million) and Indians (0.23 million). These ethnic differences have shaped the history and marketisation of aged care services in Malaysia, particularly in influencing the demand for eldercare services. According to the United Nations World Population Prospects (the 2024 revision), the number of individuals aged 60 and above in Malaysia is projected to increase from 4.1 million (11.6%) in 2024 to 5.9 million (15%) over the next decade.[7] Additionally, Malaysia had a gross national income per capita (Atlas method) of US$11,970 in 2023 and is expected to breakthrough the middle-income trap and become a high-income country in the next few years.[8]

The care economy is crucial for the transition to a high-income economy because by investing in the aged-care sector services and infrastructure, we address the needs of an ageing population while creating new jobs. We need to capitalise on the economic opportunities arising from a growing demand for LTC facilities and services but we must also ensure equitable access to high-quality care. The reliance on traditional family caregiving must be strengthened and augmented by state- or market-provided services.

Table 5.2.1 Distribution of older persons (60 years and above) by state/region/territory, 1980-2020

	1980			2000			2020		
State/ region/FT	N60+ '000	%60+	Mdage	N60+ '000	%60+	Mdage	N60+ '000	%60+	Mdage
Johor	89.6	5.4	19.0	172.4	6.3	24.5	401.8	10.0	29.3
Kedah	68.4	6.1	19.5	130.9	7.9	23.1	257.3	12.1	28.0
Kelantan	55.2	6.2	18.4	94.1	7.3	18.8	180.5	10.1	24.4
Melaka	30.7	6.6	19.4	51.1	8.0	24.3	97.2	9.7	29.2
Negeri Sembilan	37.0	6.4	19.1	63.4	7.4	23.9	127.1	10.6	29.8
Pahang	37.5	4.7	18.6	69.8	5.7	22.2	149.9	9.4	28.8
Perak	111.1	6.1	19.3	189.8	9.3	25.1	335.0	13.4	31.0
Perlis	10.7	7.2	21.9	18.8	9.2	23.9	32.9	11.5	28.5
Penang	63.1	6.6	22.0	103.6	7.9	27.0	194.9	11.2	31.8
Sabah	33.4	3.2	18.3	100.2	3.9	20.1	276.7	8.1	26.4
Sarawak	74.1	5.5	18.8	133.5	6.5	23.6	282.8	11.5	30.9
Selangor	73.0	4.8	20.4	189.6	4.5	24.5	714.4	10.2	31.6
Terengganu	31.4	5.8	18.4	54.9	6.1	19.3	102.4	8.9	26.4
WP KL	44.4	4.5	22.1	75.0	5.4	26.6	181.2	9.1	33.6
WP Labuan	-	-	-	2.3	3.1	21.7	6.7	7.0	27.7

WP Putrajaya	-	-	-	-	-	-	3.0	2.7	27.3
Malaysia	759.6	5.5	19.6	1,451.7	6.2	23.6	3,343.8	10.3	29.7

Source: Department of Statistics Malaysia, 2001, 2011 and 2024[9]

5.3 Demand and supply
Sizing up aged-care sector

The care economy encompasses both paid and unpaid activities related to caregiving, which are fundamental to human productivity.[10]

Caregiving involves not only physical assistance but also socioemotional support for individuals who depend on others for their wellbeing. To assess effectively the aged-care industry, it is essential to consider some key assumptions. First, we need to identify the size of the care-dependent population in Malaysia before we can assess if their care needs are being met. For those whose care needs are being met, it is useful to determine whether this support comes from formal care, informal care or a combination of both. This relationship can be expressed through the following equation:

$$\text{Care-dependent population} = \text{unmet needs} + \text{met needs (informal care x formal care)}$$

Dependency refers to a prolonged state in which individuals require assistance or significant help from others to cope with daily activities, such as eating, bathing, dressing and using the toilet. There are various methods to estimate the adult care-dependent population based on health and functional measures.

Past studies have used the Activities of Daily Living, the Washington Group Disability Measure, physical mobility questions and other disability assessments.[11] The National Health and Morbidity Survey (NHMS) 2019 dedicated an entire chapter to disability, measured using the Washington Group on Disability Statistics question sets. The survey found that the prevalence of disability in 2019 among adults aged 18 years or above was 11.1%, while it was 4.7% among children aged 2-17.[12]

The study, which surveyed 4,703 living quarters and interviewed 14,965 respondents, included an assessment of difficulty in self-care. The NHMS 2019 estimated that about 9.1% (295,074) of the 3.2 million older persons aged 60 years and above face difficulty in self-care and require some form of assistance.

Assessing met and unmet care needs among care-dependent older persons presents several challenges. One major limitation is the lack of comprehensive and robust data to quantify the scope and economic value of family caregiving, although living arrangements of older persons are often used as a common proxy measure. In Malaysia, older persons (aged 60+) constituted 62.9% of the total adult care-dependent population in 2019 (Table 5.3.1). The responsibility of caring for ageing parents remains with adult children and less than 1% of the older population reside in institutions.[13]

This dynamic reflects the persistent tension between traditional family caregiving expectations and the increasing need as well as demand for formal aged-care services, driven by demographic shifts. As Malaysia's ageing population continues to grow, understanding and addressing the disparity between informal and formal caregiving structures is key to developing sustainable LTC solutions.

Table 5.3.1 Adult care-dependent population by age group, 2019

Age group	Difficulty in self-care[14]			
	Count	Estimated population	Prevalence	95% confidence interval
18-29	17	45,626	0.7	0.34-1.26
30-39	18	33,025	0.6	0.35-1.19
40-49	24	45,219	1.3	0.59-2.75
50-59	45	50,004	1.6	1.10-2.45
60-69	77	105,874	5.2	3.96-6.87
70-79	88	91,440	10.1	7.49-13.37
80 & above	80	97,760	33.0	24.57-42.75
Malaysia	349	468,946	2.1	1.81-2.54

Source: Institute of Public Health (IKU), NHMS 2019[15]

Traditionally, caregiving responsibilities have fallen on families, primarily women, who have long been seen as main carers for the young and old alike. However, this arrangement is becoming increasingly untenable because of several factors. Changing family structures, characterised by smaller household sizes and increasing mobility, have reduced families' capacity to provide care. Urbanisation exacerbates the issue, as many relocate to cities for work and education, often

leaving behind older family members.[16] Women's growing participation in the labour force also intersects with conventional gender roles, affecting and being affected by caregiving expectations.[17]

With more and more people living longer, they are more likely to develop chronic illnesses and disabilities that require long-term or intensive care. Up to a point, many family caregivers struggle to cope and may require training, support, and assistance. This places significant strain on families, communities and the state to provide adequate, accessible, and equitable aged care.

Assuming that families remain the primary source of care in later life, a critical shortage of affordable and accessible formal care services leaves few viable options for respite. This contributes to cases of elderly abandonment and bed blocking in public hospital wards.

Meanwhile, home and community-based care for older persons remains scarce and largely unregulated. While institutional aged care or care for older persons in residential settings has a longer history, access remains limited. In 2022, there were 418 registered aged-care centres under Jabatan Kebajikan Masyarakat (Department of Social Welfare – JKM), with 2,122 care workers supporting 9,648 older residents (Table 5.3.2.3). However, the actual number of such facilities is likely closer to 1,000 if we include unregistered ones. In 2021, the Health Ministry (MOH) conducted in-situ Covid-19 vaccinations for staff and residents of 808 aged-care centres and old folks' homes nationwide.

The Care Centres Act 1993 (Act 506) regulates private and non-governmental organisation (NGO) homes for vulnerable populations, including older persons, persons with disabilities (PWDs) and children (e.g. childcare centres and orphanages). Most registered care centres for older persons are residential (96.7%), while the majority of childcare centres (77.8%) and disability care centres (73.2%) operate as day care or non-residential facilities.[18] This distinction is reflected in the caregiver-to-resident ratio in annual welfare statistics (Fig. 5.3.1), highlighting the increasingly intensive nature of residential aged care as older persons become frailer over time. The number of registered care facilities has steadily grown, but this does not account for many unregistered aged-care homes, 15 government-operated old folks' homes (state or federal) or the small number of licensed nursing homes (rumah jagaan kejururawatan swasta berlesen) regulated under the Private Healthcare Facilities and Services Act 1998 (Act 586).[19]

With the passage of the Private Aged Healthcare Facilities and Services Act 2018 (Act 802), new regulations are expected to take effect in 2025.

Table 5.3.2.1 Statistics of registered care centres for children, 2009-2023[20]

Year	Childcare centres					
	Number		Type		Ownership	
	Carers	Child	Daycare	Residential	Private	NGO
2023	4,506	29,829	1,073	273	1,097	249
2022	4,895	33,263	1,050	300	1,080	270
2021	4,936	37,419	999	263	1,025	237
2020	4,726	36,207	864	287	887	264
2019	4,578	34,090	805	289	851	243
2018	3,968	26,934				
2017	3,870	26,505				
2016	5,013	35,491				
2015	4,200	28,267				
2014	3,767	25,685				
2013	3,262	22,435				
2012	2,744	18,839				
2011	1,763	12,186				
2010	976	7,620				
2009	1,004	8,378				

Source: JKM (2010-2024)[21]

Table 5.3.2.2 Statistics of registered care centres for PWDs, 2009-2023[20]

Year	PWD centres					
	Number		Type		Ownership	
	Carers	PWD	Daycare	Residential	Private	NGO
2023	1,181	5,792	167	60	93	134
2022	1,254	6,244	161	59	100	120
2021	1,301	6,176	145	57	76	126
2020	1,378	8,000	138	60	74	124
2019	1,296	7,901	125	59	64	120
2018	1,328	7,560				
2017	1,160	6,870				
2016	1,591	9,569				
2015	1,172	6,282				
2014	1,089	5,724				
2013	1,046	5,474				
2012	999	5,246				
2011	869	4,385				
2010	490	2,956				
2009	538	2,483				

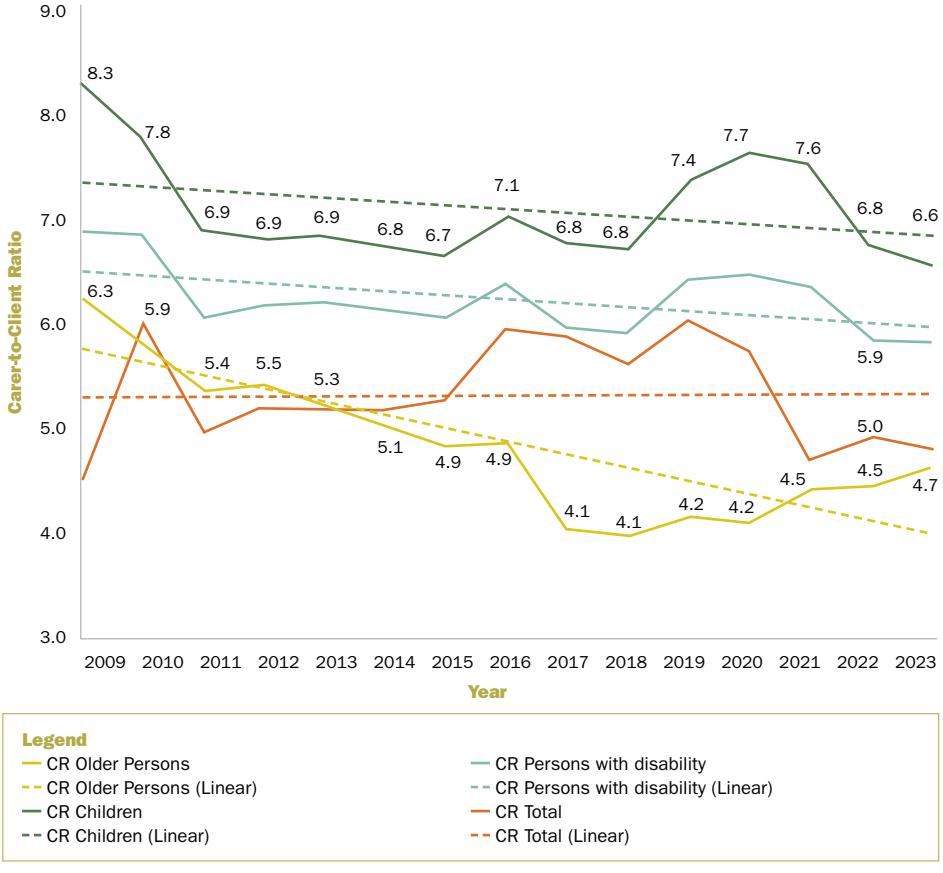
Source: JKM (2010-2024)[21]

Table 5.3.2.3 Statistics of registered care centres for older persons, 2009-2023[20]

Year	Aged-care centres					
	Number		Type		Ownership	
	Carers	OP	Daycare	Residential	Private	NGO
2023	1,786	8,360	30	400	355	75
2022	2,122	9,648	14	404	342	76
2021	1,838	8,241	8	376	314	70
2020	1,860	7,818	10	368	312	66
2019	1,758	7,440	15	343	296	62
2018	1,706	6,927				
2017	1,582	6,518				
2016	1,627	8,025				
2015	1,290	6,334				
2014	1,121	5,714				
2013	973	5,168				
2012	849	4,644				
2011	648	3,521				
2010	459	2,720				
2009	276	1,738				

Source: JKM (2010-2024)[21]

Fig. 5.3.1 Caregiver-to-resident ratio for different centres, 2009-2023



Source: JKM (2010-2024)[22]

An analysis of the registered care centre statistics reveals notable trends. While the total number of care centres has been growing at an annual rate of 6.5%, the average number of residents per facility has declined – except in aged-care facilities. This highlights the evolving and multifaceted nature of the care economy, which is more dynamic than previously recognised. Many key aspects – such as shifting caregiver roles, economic value of unpaid care work and impact of demographic changes – remain poorly understood. This underscores the urgent need for further research to inform policies and support systems that address the sector's growing complexities.

The next section examines the challenges and opportunities within Malaysia's emerging aged-care industry, including regulatory gaps, workforce shortages and cultural attitudes towards the commercialisation or marketisation of elder care. Additionally, we explore untapped potential for social and technological innovations that could reshape the future of aged care.

5.4 Issues and opportunities of aged care

It is important to understand how the aged-care industry in Malaysia arrived at its current state so that we can appreciate better the strategic directions that may define its future.

Since pre-independence Malaya, charity-run old folks' homes for unmarried and ageing migrant workers have played an integral role in providing care and support for the vulnerable elderly. Majlis Pusat Kebajikan Se-Malaysia (the Central Welfare Council of Malaysia), for example, has been a key partner to JKM and its storied history left an indelible mark on the aged-care sector until today.[23]

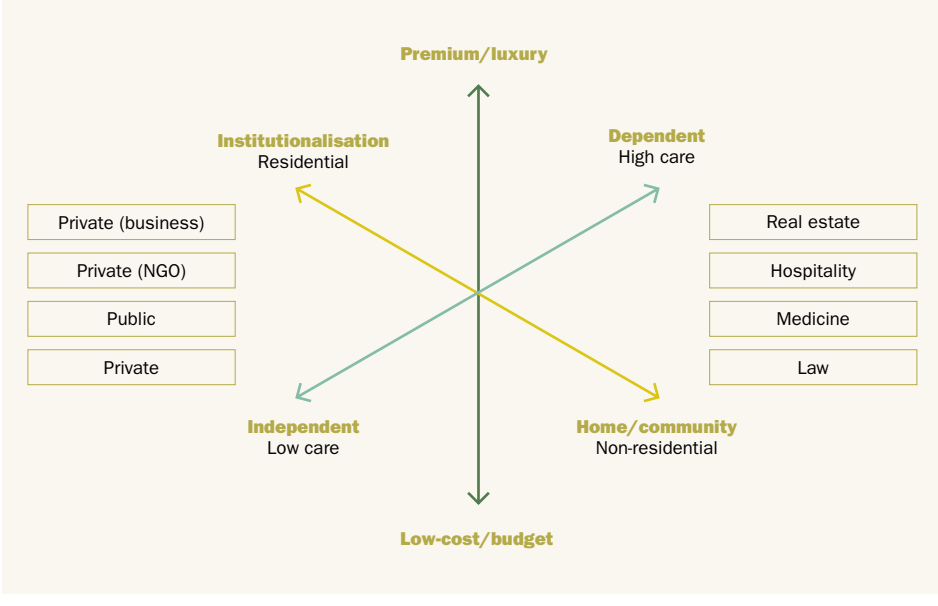
In the late 1990s, the liberalisation of Malaysia's healthcare sector transformed significantly the eldercare landscape, leading to the emergence of new nursing homes and aged-care facilities that are increasingly in demand in urban areas and towns.[24] Nevertheless, the decision to send elderly family members to care centres is often perceived as a form of neglect and abandonment because of sociocultural values surrounding filial piety. Even when families struggle to provide proper care because of work commitments or other challenges, feelings of guilt, shame and social stigma sometimes result in elderly family members being kept at home despite inadequate support for both the older person and caregiver alike.

A watershed moment in the aged-care sector occurred in 2012 when "senior living" was identified as a significant business opportunity (BO) under the Health National Key Economic Areas.[25] Various avenues for growth in the senior living and aged-care sectors were explored, including modern retirement villages, assisted living and nursing homes, long-term care services, community and home-based care businesses, and – to a lesser degree – transborder care and gerontechnological solutions. Many of the new entrants, key players and legislative developments in the aged care industry today can trace its beginnings to the BO onboarding session at Kelana Jaya in September 2012. The tacit government support helped create a favourable environment for legislative reform and investment in eldercare solutions, particularly in response to the growing need for comprehensive senior living options across the country. Modern retirement villages are relatively new to Malaysia, whereas pondok, or religious learning centres for Muslim elders, have historic roots but remain outside the mainstream aged care system.

I. Segmenting aged care market

We conceptualise the continuum of aged care in Malaysia along three axes: high-low care, residential-non-residential care and premium-low-cost care. Rather than dividing or segmenting the aged-care sector according to actors (e.g. by the government, civil society or businesses), each axis represents different dimensions of care needs, cost and location. Together, they provide a framework to understand the variety as well as gaps of care services for the elderly.[26]

Fig. 5.4.1 Conceptualisation of aged care in Malaysia: who, what, where and how much?



Source: Authors' compilation

It is important to note that the aged-care situation in Malaysia is unique for several reasons.

As mentioned, varying rates of demographic transition and historical factors have resulted in a majority of aged-care residents being Chinese. Most private facilities and services cater primarily to this community, influenced by both economic and cultural factors although there is a clear and rising demand for Islamic care homes. Charitable homes rely primarily on grants and donations, while private aged-care centres and nursing homes sustain themselves through monthly fees paid by adult children or next of kin. This is a common – and indeed preferred – distinction, as little public aid is available for fee-based facilities.

The economic value of the services provided by the aged-care sector is often underestimated and the notion of "free" versus "paid" aged-care services presents

a false dichotomy because it oversimplifies the complexities of eldercare. There are considerable trade-offs as unreliable or limited public financing models might hamper an operator's ability to manage high or intensive care patients, and some providers have to cross-subsidise to reduce the burden on out-of-pocket payments from families. We have observed diverse arrangements on transportation, medications and supplemental care but the private aged-care sector, in general, remains heavily reliant on the public healthcare system.[27]

Construction-wise, only a small fraction of residential or non-residential facilities are purpose-built while most are renovated, refurbished or retrofitted from domestic buildings (e.g. bungalow, semi-detached or terrace house). Like kindergartens and childcare facilities – and perhaps even more so due to social stigma and cultural values – there is a resistance among local communities to the setting up of aged-care centres or nursing homes in their neighbourhoods – a classic "not in my backyard" mentality.

Because of a limited understanding on the importance and benefits of senior housing alternatives, conventional aged-care facilities and services are being perceived as disruptive and unwelcomed developments that could negatively impact on the property value in an area. The local authorities, particularly, play a critical role apart from regulation and oversight by the fire brigade, MOH and JKM. The Physical Planning Guideline for Older Persons (GP031-A) in 2018 is the second version published since 2013 and Department of Town and Country Planning (Jabatan Perancangan Bandar dan Desa) has communicated plans for its revision.[28]

Usually, residential care or institutionalisation offers higher levels of care for individuals who require continuous medical supervision, especially when families cannot cope with the complex care needs of the elderly with multiple disabilities and/or severe health conditions. It is also the main reason it is so costly. However, in Malaysia, the out-of-pocket cost of residential care is sometimes more related to amenities (i.e. air-conditioning and room sharing) than quality or intensity of care. Because of a lack of home or community-based care packages – and the fact that it is more cost-efficient to put the elderly with high care needs in a facility cared for by a team of trained professionals rather than sending individual nurses to provide in-home care – a facility can optimise resources, reduce overhead costs and ensure that staff are able to manage multiple patients in a controlled environment. This would lead to better care outcomes and lower overall expenses.

However, this also raises the ultimate question: what do our elderly and their family members want?

II. What do older persons want?

In Malaysia, the care needs of older persons are still predominantly met by family members, reflecting deep-rooted cultural and religious expectations of filial piety and responsibility. However, this is fast becoming unfeasible or unsustainable. Past studies by the Institute of Gerontology (IG) and Malaysian Research Institute on Ageing (MyAgeing®) have consistently shown that adult children and their spouses are expected to care for ageing family members and that most elderly persons engaged prefer ageing-in-place (77.6%).[29]

This is consistent with findings from the latest Malaysian Ageing and Retirement Survey (MARS) Wave-2 where 83% of the respondents wish to age in place. In the MARS study, spouse (39.6%), daughter (31.8%) and son (19%) were identified as individuals most likely to care for the respondents when they are in need. The 2022 survey also indicated that only 16.7% of the respondents were prepared to move to an assisted living facility, compared to 61% who were ready to receive care services at home.[30]

The wealth of data, both qualitative and quantitative, show us that a majority of older persons in Malaysia are "institutionalisation averse" and prefer independent living in the community. If we analyse the microdata from past household expenditure surveys by the Department of Statistics Malaysia, we can see that the increase in the share of households with only older persons did not just come from the elderly living alone (Table 5.4.1).

Table 5.4.1 Household size and composition by age, 1999-2019

Household composition	1999			2009			2019		
	n	%	Hhsize	n	%	Hhsize	n	%	Hhsize
One-person household									
Adult (18-59)	259	9.4	1.0	436	6.7	1.0	809	4.9	1.0
Older person (60+)	77	2.8	1.0	159	2.4	1.0	540	3.3	1.0
Multi-person household									
No older person (OP)	1,861	67.4	4.8	4,350	67.0	4.6	9,530	58.3	4.3
Mixed OP & non-OP	516	18.7	4.9	1,373	21.1	4.7	4,678	28.6	4.4

OP only	48	1.7	2.0	177	2.7	2.0	797	4.9	2.0
Total households	2,761	100.0	4.3	6,495	100.0	4.2	16,354	100.0	3.9
Hh with at least 1 Child (<18)	1,859	67.3	5.4	4,083	62.9	5.2	8,772	53.6	5.1
Hh with at least 1 Older Person	641	23.2	4.2	1,709	26.3	4.1	6,015	36.8	3.8

Source: 30% household expenditure survey (HES) microdata (DOSM, 2012; 2020)[31]

While multigenerational living and extended family households are on the decline – partly due to housing design, the data reveal a notable rise in older households where older persons are ageing alongside their spouse in empty nest settings. In an increasingly mobile workforce, adult children often no longer live with or near their ageing parents. Considering successive government policies to increase Malaysia's female labour force participation, we are in a transitional phase where the commodification and marketisation of unpaid family care is taking place.

As care services become increasingly market-driven, the state's role is shifting from that of a social welfare provider to a regulator and facilitator of the care economy, exemplified by the recent spate of activities to put the care economy at the centre of the country's national development agenda.[32] For example, the Ministry of Women, Family and Community Development organised a series of workshops to develop a national plan of action for the care industry after the prime minister called for the empowerment of women's roles in the care economy to boost their labour force participation in the final phase of the 12th Malaysia Plan in September 2023.

This period of transition is marked by a growing dependence on private aged-care centres, community-based care services and paid home caregivers. These long-term care models offer varying levels of support depending on needs, costs and purposes.

It would be a mistake, however, to assume that there are no past or current alternatives between unpaid family and professional caregivers. Traditionally, Malaysian families have relied on kinship networks to support caregiving responsibilities, especially when no close family members (i.e. daughters or daughters-in-law) are available.

Yet, the Chinese community in Southeast Asia is certainly no stranger to mui tsai, ma jie or amah – specific groups of women who work in servitude as domestic helpers during the colonial period.[33] Despite their disappearance by the 1970s, the demand for domestic helpers remains with maids from the Philippines and Indonesia catering to this in Malaysia. Rural girls as bondservants were

replaced by foreign maids and the middle-class continues to employ domestic workers as a more affordable alternative to professional caregivers. These contemporary domestic workers face many of the same challenges as their historical counterparts, such as abuse, exploitation, low wages and lack of legal protection.[34]

III. Manpower challenges and licensing issues

The real challenge to sustainable home- or community-based aged-care services goes beyond the use of domestic helpers or servants, it includes overdependence on foreign workers in the formal health and social care sector, whether residential or non-residential.

The hiring of foreign labour is a short-term solution to address local workforce shortages but this reliance is ultimately unsustainable. It serves as a quick band-aid fix that does not address deeper structural issues within the aged-care sector, particularly concerning manpower shortages, inadequate training and poor LTC financing models. Without addressing these fundamental problems – such as through creating a stable, skilled local workforce and developing long-term funding mechanisms – Malaysian families will be compelled to rely on whatever care arrangements they can afford, even if these options carry significant risks and long-term consequences.

The manpower conundrum is the most obvious issue with broad and lasting impact on the industry. High staff turnover is a common problem for operators, exacerbated by a scarcity of trained personnel because of poor remuneration. Many operators believe that the aged-care industry cannot be a fully commercial-driven one.[35]

Meanwhile, the gap between registered and unlicensed aged care facilities remains wide, even as these services are found primarily in the more developed states (Table 5.4.2). Consider, for example, one of the five key purposes of the Association for the Residential Aged Care Operators of Malaysia: "to support training and capacity building towards the registration, licensing and accreditation of elderly care facilities and services."[36] This reflects the priorities and preoccupation of the local aged-care industry players and thus serves as a stark reminder of the ground reality.

Table 5.4.2 Distribution of residential aged-care facilities by state, 2022

State	Health Ministry		Department of Social Welfare	
	Vaccinated	Act 586	Act 506	Federal/ state
Johor	72	3	57	1
Kedah	21	1	18	1
Kelantan	3	0	3	1
Melaka	38	1	26	1
Negeri Sembilan	20	0	35	1
Penang	33	0	29	0
Pahang	32	1	12	0
Perak	137	1	80	3
Perlis	4	0	1	1
Sabah	16	0	8	2
Sarawak	48	5	8	2
Selangor	308	2	100	2
Terengganu	5	0	3	1
WP Kuala Lumpur	70	4	24	0
WP Labuan	0	0	0	0
WP Putrajaya	1	0	0	0
Malaysia	808	18	404	16

Source: MOH, 2023;[37] JKM, 2023[38]

IV. Assistive technology and gerontechnological solutions

An often-overlooked opportunity is the use or application of technology in aged care and everyday living. The care economy offers huge potential for tech-driven solutions, benefiting stakeholders through innovative design, products and systems that help elder care to be more affordable, accessible and efficient.[39] It is not a coincidence that the new wave of service providers makes full use of smartphone applications, not just in care-work monitoring but also service booking and carer-matching platforms.

New and novel ways of bringing demand and supply together also come with different business models that push mobile- and on-demand care to the forefront. Here, we can see regulatory actors playing catch-up as aged-care entrepreneurs devise better care-service delivery packages. Some provided Internet of Things solutions for aged-care operators, while others focused on product customisation. Telemedicine, artificial intelligence-powered health monitoring, smart-home systems, on-demand transit services and virtual caregiver-support platforms are enhancing the aged-care landscape.

The integration of technology has not only significantly impacted on the quality of care but also forced us to rethink traditional approaches to care and support for older persons. In the years to come, we will see a surge in the silver market, including assistive devices and mobility aids, such as electric wheelchairs and smart walkers, intelligent ambient home systems with voice-activated assistants, health-monitoring wearables (heart-rate trackers, glucose monitors), caregiver emergency alerts and medication-adherence monitors.

These advancements help the elderly to be more independent and make ageing-in-place a reality. The government, therefore, must put in place policies that support and invest in gerontechnological innovations to ensure affordability and widespread adoption, thus further expanding the silver economy.

V. Lessons and insights from purple economy

As the country faces an increasing care-dependent adult population, shifts in caregiving responsibilities and the marketisation of eldercare services are likely to affect adversely older persons' access to quality care and support in later life, unless these changes are matched by appropriate policy responses.

With Malaysia's status as an ageing society, the balance between expectations and reality of care requires careful consideration, especially in the gendered dynamics of care work. In this vein, the care economy is intricately linked to the "purple economy" – an economy driven by women, both as primary caregivers and as a significant portion of the care workforce.

The care economy in Malaysia, like many other countries, is heavily gendered. Women dominate both unpaid caregiving roles and the formal care workforce but they are not adequately compensated. For example, women make up 71.8% (401,700) of the total employed persons in the Human Health and Social Work Activities category in 2020 but their average pay is still lower than their male counterpart.[40]

There is also a growing recognition of the need to involve men in caregiving roles, both within families and professionally. Encouraging men to take on caregiving responsibilities could alleviate the burden on women and ensure a more equitable distribution of care work.

Furthermore, gender-sensitive policies are needed to support caregivers, including flexible-work arrangements and financial incentives for those providing unpaid care. Without addressing gender inequality at home and at the workplace, women's role in the care economy remains invisible and undervalued. Closing the gender gap in care is not just about pay but also understanding the need for parental or family leave, including provisions for community and home-based care services.

For inclusive and sustainable economic growth, we need to create more resilient systems that recognise care as the foundation of all human activities. Without care work, whether paid or unpaid, other sectors like business, education, and healthcare would not function effectively. Therefore, care is not just a private responsibility but a public good that sustains productivity, wellbeing and social stability. By valuing and investing in care through fair wages, social protection, and supportive workplace policies, we can build a more equitable, resilient, and sustainable economy that prioritises human wellbeing over profit.

5.5 Challenges

The main challenges to Malaysia's aged care ecosystem can be summarised into the following points.

I. Care recipients

Different care service providers – whether public, private or NGOs – are subject to varying levels of regulation but there continues to be regulatory and monitoring oversight. Ensuring that facilities and care workers are licensed, registered and meeting minimum standards is crucial for safeguarding the wellbeing of older

persons. Unfortunately, enforcement remains inconsistent, often resulting in disparities in care quality.

The rights of older persons to care and security are fundamental principles that ensure their dignity and quality of life. Often, older Malaysians are not given the autonomy to make decisions and choices about their own care. Promoting and protecting these rights is thus essential to ensure that older persons can live fulfilling lives, maintain their independence and receive the care and security they deserve. Consent and advance directives are critical components of care for older persons, ensuring that their rights and preferences are respected throughout the caregiving process.

II. Workforce

There is a persistent shortage of qualified caregivers in both the formal and informal sectors. Manpower issues have been a constant problem for the aged-care industry. Low wages and demanding work conditions lead to high staff turnover and it is difficult to retain skilled carers or attract new talent. Because of limited training and career professional development, caregivers suffer from emotional and physical burnout. As the aged-care workforce in Malaysia is largely unregulated, many caregivers lack formal certification or accreditation.

Meanwhile, the contributions of caregivers, particularly unpaid family members, are often unrecognised and unsupported. This lack of acknowledgment could lead to feelings of isolation and undervaluation. There is a pressing need for the professionalisation of the sector, including enactment of standardised training, certification standards and fair remuneration for caregivers. Moreover, the gender imbalance in care work must be addressed, with efforts to encourage more men to enter the profession.

III. LTC financing

The financial burden of LTC is a significant concern for families and the state. The cost of institutional care, home-based services and even informal caregiving can be prohibitive. The high cost of care, limited public funding and support, as well as the lack of insurance options are driving up out-of-pocket expenses that could lead to financial burden, strain and stress for families.

Exploring alternative financing options, such as insurance schemes or subsidies for lower-income families, is essential. Additionally, technology-augmented care – such as telemedicine, remote monitoring and assistive devices – presents opportunities to enhance care while reducing costs.

However, the integration of these technologies into long-term care models remains in its infancy in Malaysia. While residential care may be a solution for families who are unable to provide sufficient support for older persons, accompanying costs and unpredictability in care quality make it an expensive and unsustainable alternative. We need homes and community-based services that are affordable to create a level playing field for low- and middle-income families.

The situation of home and community-based care is changing with the development of smart technology and assistive devices in improved monitoring, as well as a more supportive environment for ageing. Many Western and European countries have aggressively promoted age-friendly paradigms that not only seek to increase care accessibility and lower costs but also highlight the value of social inclusion and support networks for older persons.[41]

As a proposal, we need to develop a clear industry-wide plan of action to realise the full potential of the aged-care economy for seniors and their family members. The Covid-19 pandemic exposed the vulnerability of older persons in institutions and in community settings, thus the need to reevaluate our approaches to strengthen community-based health and social care services for the elderly.[42] Policymakers should prioritise comprehensive action that includes both formal and informal care systems.

5.6 Beyond LTC: the longevity economy and way forward

WHO notes that the demand for LTC is likely to increase dramatically, forecasting that the number of older persons in need would double by 2050.[43] The senior living industry is poised for further growth, driven by demographic changes and government support for the aged-care sector. As the population ages rapidly, there is a rising demand for formal aged-care services with a tandem increase in the silver economy. The demand for such care is diverse, ranging from assistance with daily chores to comprehensive medical supervision.

However, Malaysia currently lacks a comprehensive LTC infrastructure, with relatively limited nursing homes and aged-care facilities compared to an increasing number of older persons. Moreover, the quality and accessibility of these services vary widely. Despite the critical need for long-term care, many programmes are underfunded and lack the capacity to fulfil increasing demand. The high cost of aged care services is a substantial barrier, especially for low-income families who may struggle to obtain critical support and assistance.

The government must adopt a holistic strategy to meet the changing needs of an ageing Malaysian population. This involves increasing the availability and quality of LTC programmes and services, supporting community-based care

models and providing financial assistance to needy families. Furthermore, public awareness campaigns are crucial in shifting the cultural conceptions of ageing and care.

In conclusion, Malaysia's demographic trend towards an older population requires immediate attention and action from all sectors of society. As the traditional caring model becomes increasingly unworkable, intelligent solutions and collaborative efforts are critical to ensure that older individuals receive the care and assistance they need to lead satisfying lives.

Malaysia's ageing population presents both challenges and opportunities for the care economy. Old age is not just about healthcare and social support. By capitalising on this latent potential, Malaysia might alleviate the fiscal strains of an ageing population while fostering a more equitable, intergenerational economy.

Addressing the growing demand for LTC requires a comprehensive approach that includes improving the quality and accessibility of care services, professionalising the care workforce and ensuring sustainable financing options. Gender dynamics play a crucial role in shaping the future of care – involving both men and women in the sector is essential for its success. By harnessing the potential of the longevity economy and integrating technology into care models, Malaysia can build a more resilient and inclusive system of LTC for older persons.


GHASSAN
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6

Evaluating provision of care for children

Quality varies among childcare centres, kindergartens and care centres, call for more resources to overcome gaps

Anisa Ahmad
Debbie Ann Loh

6.1 Introduction

Malaysia's declining fertility rates, now at an average of 1.6 children per family, put the country at the third lowest rank in Southeast Asia, after Singapore and Thailand.[1] This downward trend may be attributed to several factors. These include delayed marriages, career demands, shifting priorities, evolving family dynamics, high cost of living and a preference to delay or forgo childbearing – resulting in shrinking family sizes.[2]

Still, childcare has traditionally remained the primary responsibility of women, placing a disproportionate burden of informal and unpaid care on women.[3] Dictated by social norms and gender stereotypes, this restricts women's participation in economic opportunities.[4]

Such is evidenced by Malaysia's low female labour force participation rate (LFPR) of 56.6%, in contrast to male LFPR of 83.2%, as of May 2024.[5] About 5.1 million women, mostly aged between 25 and 54, are outside the labour force largely because of household or family responsibilities. This leads to missed economic contributions, widens gender inequality and creates financial hardships for families.

Boosting women's employment and facilitating re-entry would support economic growth, reduce gender inequalities, address workforce shortages from an ageing population, as well as diversify and bolster household income.[6] Access to affordable and quality childcare must improve to facilitate this progress.

To illustrate, childcare services positively impacted maternal labour market outcomes across 21 low- and middle-income countries.[7] Designing childcare hours to correspond better with women's work hours and extending services for older children facilitated full-time employment for mothers, including those living in rural areas. The proximity of childcare to work or home also resulted in time and cost savings.

As of 2023, children constituted 27.4% of Malaysia's population, with 4.72 million boys and 4.42 million girls.[8] Of these, about a quarter or 2.35 million are under the age of five.[9] By 2050, projections indicate that children will only comprise 20% of the population. Concurrently, the number of older persons (60 and above) will surpass the number of children, partially driven by lower mortality rates and increased life expectancy. Thus, strategic investment in childcare to-

day promises long-term benefits to the nation, with improved health outcomes, increasing economic productivity and lower delinquency rates, as highlighted by James Heckman, a Nobel prize-winning economist.[10]

Malaysia is a signatory to the United Nations Convention on the Rights of the Child (UNCRC) 1989, which defines a child as "every human being below the age of 18 years."[11] UNCRC enshrines the rights of every child, guided by four principles of non-discrimination, best interests of the child, right to be heard and right to life, survival and development.[12] Such parameters are mirrored in Malaysia's Child Act 2001 (Act 611).

Against this backdrop, it is important to assess if Malaysia has truly upheld the rights of children. Nelson Mandela once incisively said: "There can be no keener revelation of a society's soul than the way in which it treats its children."

Within the context of the care economy, this paper will focus on evaluating the provision of care for children in centres, which covers childcare centres (ages 0-4), kindergartens (4-6) and care centres (4 to below 18). We will present an overview of care services for children.

The following section discusses the needs, challenges and gaps in legislation and regulations, the workforce, child protection, and financing related to the care economy of children. The roles of the public, private and voluntary sectors are then explored. The paper concludes with recommendations towards providing quality and equitable care for all children in Malaysia.

6.2 Overview of available services

Early childhood care and education in Malaysia are categorised into two types of service by age groups: childcare for up to 4-year-olds and preschools for 4- to 6-year-olds. These early years are crucial as a child undergoes rapid brain development and reaches physical, cognitive, social and emotional developmental milestones. In fact, a child's early life experiences, particularly during the first five years, have been shown to impact his/her performance in school and are a predictor of wellbeing in adulthood.[13]

I. Childcare centres

The Child Care Centre Act 1984 (Act 308) defines childcare centres (taman asuhan kanak-kanak – Taska) as any premises that provide paid care for four or more

children under the age of four. Taska is governed by the Child Care Centre Act 1984, Child Care Centre Act 1984 Amendment – Act 1285/2007 and Child Care Centre Regulations 2012. These nurseries support early years' learning through structured activities and play.

Taska can be government funded, privately owned or run by NGOs. The four categories of Taska are institution based, workplace based, community based and home based. Ten or more children are allowed in Taska except for home-based Taska (four to nine). Government-funded facilities offer subsidised options with standard curriculum in Bahasa Malaysia, making them accessible to low-income families. Private childcare centres often charge more, differentiated by specialised curriculum, enhanced facilities and activities.

All childcare providers, including operators, managers, supervisors and child educators, must attend and pass the Kursus Asuhan dan Didikan Awal Kanak-Kanak PERMATA (PERMATA Early Childhood Care and Education Course – KAP) certification. Additionally, they must complete the food handler and cardiopulmonary resuscitation (CPR) trainings as stipulated by the Health Ministry. These mandatory trainings equip those entrusted with caring for young children with necessary skills and knowledge.

The government encourages private sector employers to establish workplace childcare centres that are registered with the Department of Social Welfare (Jabatan Kebajikan Masyarakat – JKM). These companies are offered tax incentives, including double deduction on expenses related to establishing and upkeep of a childcare centre. Companies are also eligible for double deductions on childcare allowances for their employees.[14]

However, high operating costs have led to a low uptake, with only 60 workplace childcare centres established compared with 187 centres in government workplaces as of 2022. To mitigate this, prioritising the double deduction on childcare allowance is recommended where workplace childcare centres are not feasible to retain working parents.

Cost is a major barrier for parents intending to send their children to childcare centres. In response, community-based childcare centres offer affordable, accessible and quality childcare for low-income parents in urban and rural areas, with funding from the federal or state governments. In Budget 2025, it was announced that low-income families are eligible for a subsidy of RM250 per child aged 6 and below (subject to a maximum rate of RM1,000 per family) to encourage early years' learning at registered centres.[15]

Home-based childcare centres (HBCC) are preferred by parents because of their lower carer-to-child ratio and personalised setting. However, only those serving four to nine children are mandated to register. Many remain unregistered because of a lack of awareness or tedious procedures, placing children at risk of abuse or neglect.[16] The Selangor government is proactively working to streamline

local council regulations to ease the registration of HBCCs.[17] Quality care in HBCCs revolves around carer-to-child ratio, caregiver education and training, health and safety measures, and physical environment.[18] These provide a benchmark for ensuring safe and well-regulated care.

II. Kindergarten

In Malaysia, kindergartens refer to taman didik kanak-kanak (Tadika) or taman bimbingan kanak-kanak (preschools – Tabika) that offer educational programmes for children aged 4 to 6. Kindergartens may have up to 25 children per class. However, special needs or integration streams are limited to seven children per class. Governed by the Education Act 1996 (Act 550), kindergartens focus on developing school readiness, serving as a preparatory ground for entry into mandatory primary schooling by seven. Hence, foundational skills, including literacy, numeracy and social interaction, along with experiential and hands-on learning, are emphasised.

Four ministries are involved in the governance of childcare centres and/or kindergartens in Malaysia (Table 6.2.1). Government-funded preschools – such as Tabika Kemas and Tabika Perpaduan – use the National Preschool Standard Curriculum (NPSC), delivered primarily in Bahasa Malaysia.

Given the variance across ministries and operations, there are calls to streamline the preschool education system nationwide, including syllabus and learning methods, for a more comprehensive early childhood education. The Education Ministry (MOE) has responded by creating a task force in the first quarter of 2024 to coordinate this effort and expedite education reforms.[19]

Table 6.2.1. Ministries involved in the regulation of childcare centres and/or kindergartens

No.	Ministry	Agency	Jurisdiction	Curriculum
1	Ministry of Women, Family and Community Development (MWFCD)	JKM	Registration of Taska or childcare centres (institution, workplace, community and home based)	Government funded: PERMATA Private/NGO: varies

2a	MOE	GENIUS/ PERMATA Division	Pusat Anak GENIUS Negara (PAGN)[20]	Quality, play based learning for 0-4-year-olds from low-income families
2b	MOE		Preschools/ Tadika	Government funded: NPSC Private/NGO: varies
3	Ministry of Unity (MOU)	National Unity and Integration Department (Jabatan Perpaduan Negara dan Integrasi Nasional – JPNIN)	Taska Perpaduan and Tabika Perpaduan	Taska Perpaduan: PERMATA Tabika Perpaduan: NPSC
4	Ministry of Rural and Regional Development	Department of Community Development (Jabatan Kemajuan Masyarakat)	Taska Kemas and Tabika Kemas	Taska Kemas: PERMATA Tabika Kemas: NPSC Affordable rates for those in rural areas

Both private and NGO-run preschools are free to use specialised curriculum, select their preferred medium of language and determine their fees. Learning centres for children with disabilities are increasing, though most are concentrated in urban centres and priced variably. Rural families often depend on the community-based rehabilitation centres (program pemulihan dalam komuniti – PPDK), though these are not without their challenges (see Chapter 5: On CBR rehab centres' challenges).

Religious departments and political parties also offer preschool education. For example, Majlis Agama Islam Wilayah Persekutuan (Federal Territory Islamic Religious Council – MAIWP) provides a two-tiered preschool education.[21] Tadika Permata MAIWP's affordable rates (between RM20-80 monthly) serve low-income families, including foreigners. Tadika MAIWP Kids is a full-day preschool with lessons primarily in English, priced at RM300 monthly.[22] Another example includes Pusat Asuhan Tunas Islam (PASTI) Islamic preschools, established under the political party Parti Islam Se-Malaysia (PAS).[23]

All these are affordable options for parents who prefer religious-based pre-primary education. Like other NGO-run learning centres, the monitoring, accountability and regulatory aspects for safeguarding deserve attention.

III. Informal care

Although early childhood care and education (ECCE) offers substantial economic, social and developmental benefits, these often remain out of reach of marginalised children. Innovative solutions, including toy libraries, playgroups and on-demand childcare services, are emerging to reduce these inequalities. For example, Re:Play, a project based in Subang Jaya, Selangor, focuses on play-based care and education for deprived communities through recycling and upcycling. This creates a circular economy that connects private sectors to communities in need.[24]

Kiddocare, a leading online platform for on-demand babysitting, connects parents with trained and screened babysitters.[25] Flexible care options offered include stay-at-home, out-of-home, pop-up or travel nanny. The platform has expanded significantly to the greater Klang Valley and major cities nationwide. In doing so, Kiddocare has empowered more than 17,000 women as professional child caregivers and served more than 63,000 families. This award-winning model has revolutionised childcare modalities in Malaysia, gaining increasing acceptance and government recognition.

Despite these innovations, they ultimately remain informal services and are thus subject to the downside associated with the category. Thus, amid their rapid expansion, maintaining quality and affordable care will be key. Developing an accessible, digitalised and affordable model for suburban and perhaps rural areas might be a promising prospect to support families across regions.

IV. Alternative care

In Malaysia, alternative care encompasses informal kinship care and formal alternative care, including foster care, legal adoption and/or institutional care. This section will focus on institutional care.

A child is placed in an orphanage or institutional care under two circumstances: 1) children who are true orphans – those whose parents have both died, or; 2) children who are unable to live with or must be separated from their parents or guardians owing to circumstances, such as parental death, abandonment, neglect, abuse and for whom the government provides protection and aid.[26]

An estimated 64,000 children in Malaysia are living in institutionalised care, in registered and unregistered settings, including care homes and shelters.[27] In 2022, only 1,457 children were reported living in residential institutions nationwide, highlighting that unregistered care institutions nationwide are grossly unaccounted for.[28]

Although it is difficult to estimate unregistered care centres, it is possible that these centres have inadequate and untrained caregivers. While supported by

well-meaning charities, religious organisations or individuals, non-compliance with the JKM's guidelines exposes the children to abuse, neglect, maltreatment, or exploitation. Further, the lack of accountability and monitoring might increase the risk of misappropriation of funds and recruitment of unscreened individuals.

Institutionalised children are accorded protection under the Care Centres Act 1993 (Act 506) and Child Act 2001. Care centres seek to provide basic needs. However, these children are at a heightened risk of development delays and suffer detrimental psychological effects, stemming from the lack of a family-like environment, loneliness and abandonment.

Thus, the introduction of family-based care (FBC) in 2016, which aims to deinstitutionalise and reintegrate children with their biological, extended families or adoptive parents, is commendable. For FBC to be fully effective, legal and policy reforms are necessary to streamline the foster-care process to facilitate the placement of children in stable family environments, reserving institutionalised care as an interim last resort.

6.3 Needs, challenges and gaps

I. Legislation and regulations

The law mandates that all childcare centres must register with JKM and adhere to the stipulated guidelines to be licensed operators. However, violations are observed with the growing numbers of unregistered Taska.[29] This non-compliance raises questions about the quality of care, education system, staff training, staff qualification and child-protection needs.

Obtaining an operating licence for childcare is non-negotiable to safeguard children in care settings and ensure compliance with guidelines. However, multi-layered governance, rules and regulations related to childcare are fragmented and often complicate the registration process for childcare, kindergartens and care centres.

While some have attempted to register, some remain unregistered because of challenges in meeting the varying local authority requirements that differ across localities.[30] This exhausts time and resources that could be better spent in actual care work. JKM has endeavoured to assist through the activation of one-stop centres at the state and district levels, necessitating more of such efforts.

Legislations in the interest of caregivers are notably missing. These include policies that support care workers through peer-support groups, skills training

and networking. These support structures cannot be undermined, particularly for a workforce that is reportedly underpaid and overworked, with limited prospects for career progression.

II. Workforce

Although the importance of child caregivers and educators has been acknowledged, the profession is not appreciated adequately. It is often considered a low-paying one that relegates the workers to a low status in the social structure.

Identifying the underlying reasons for low pay is crucial. Low wages are associated with the affordability of childcare and education, which, in turn, is determined by the quality of care, qualification and experience of teachers or caregivers, and the adult-child ratio, among others.[31] Some cite the rising cost of living or the recent increase in Malaysia's minimum wages as reasons to raise the cost of childcare.[32] However, this is not necessarily the solution, as it will negatively impact on parents with financial constraints.

Pay and hygiene factors are related to staff retention. Low pay and poor hygiene factors, which include compensation, benefits and working conditions, are push factors for high turnover rates. When care workers and child educators change frequently, this staff shortage affects multiple variables. These include daily organisational operations, finances and co-workers, who must take on additional tasks and train new hires.

Additionally, staff inconsistency has shown undesired behavioural changes in young children. These young ones often form emotional attachments with their teachers or caregivers, given the long hours spent together, and are most visibly affected by the loss.[33]

This vicious cycle of low pay, low quality and low uptake continues to plague the industry. Poor pay pushes those qualified to leave or seek higher-paying employment overseas. They may be replaced with unqualified or less qualified individuals who receive lower wages. Inadequate compensation – compounded with several factors, including a demanding workload, low managerial support and, in some cases, having to work multiple jobs – eventually leads to burnout.[34] This inevitably drains staff morale, jeopardises care quality and adversely impacts on staff retention.

Taken together, these reinforce the perception of staff's "low status" and job dissatisfaction. No surprises, thus, that enrolment in ECCE is on a decline as students opt to pursue courses that offer more attractive and rewarding career options. These dilemmas have been documented over a decade ago and continue today.[35]

Without an actionable and timebound commitment by the relevant stakeholders towards a national level recognition of childcare-related professions, a

clear career and training pathway and decent and fair wages, the trajectory of the industry and its workforce remains unchanged.

III. Child protection

In Malaysia, several laws aim to protect children and address violence and abuse. These include the Child Act 2001, Domestic Violence Act 1994, Sexual Offences Against Children Act 2017 (Act 792), Child Care Centre Act 1984, Care Centres Act 1993 (Act 506) and Penal Code, among others.

The Criminal Procedure Code and the Evidence of Child Witness Act are crucial frameworks for handling child-protection cases. A dedicated children's division established under JKM and the Sexual, Women and Child Investigations Division (D11) under the Royal Malaysia Police are responsible for child-abuse cases, sexual crimes and domestic violence.[36]

However, critical gaps remain in Malaysia's child-protection system, as child marriage and female genital mutilation continue to be practised. Furthermore, there is a lack of knowledge of the standard operating procedure (SOP) to prevent child sexual abuse and exploitation, resulting in revictimisation and failure to prosecute offenders.

Children may encounter violence in various environments, including homes, childcare centres, kindergartens or alternative care centres. They may witness or experience physical, emotional, verbal, psychological or sexual abuse. These especially involve unlicensed centres or rural areas, where abuse often goes unchecked.

Recent horrific incidences of child abuse reported at unsuspecting residential institutions gained international attention, highlighting the urgency to tackle this problem in Malaysia.[37] Furthermore, refugee, migrant and asylum-seekers are particularly vulnerable to bullying, abuse and neglect, especially those in unmonitored madrasah. Additionally, nomadic Penan indigenous girls in Sarawak have reportedly been raped by loggers and coerced into marriage for decades.[38] These underscore the urgent need for multisectoral interventions to protect the most vulnerable.

Digital connectivity, while beneficial, has perpetuated online sexual harm among children. An estimated 100,000 children aged 12 to 17 in Malaysia face online sexual exploitation.[39] Sexual predators craftily lure potential victims through in-game chatting on popular interactive gaming platforms, such as Fortnite, Minecraft, Roblox or League of Legends. Perpetrators often use grooming tactics, give game tokens to victims and apply gradual desensitisation. Livestreaming is another means for perpetrators to evade detection.[40] Moreover, grooming via social media has driven the uptick in the rape of underage girls.[41]

Refugee children are particularly at risk of online sexual abuse because of parental illiteracy, limiting their guardians' ability to monitor online activity.[42] Concerningly, some children lack awareness and are unable to differentiate good from bad interactions, feeling too powerless to challenge or defy an adult's instructions or threats.

The increased reporting of child abuse cases indicates growing public awareness and allows victims to receive the necessary assistance and psychosocial support. Yet, significant barriers persist. Some family members, teachers or caregivers may refrain from reporting abuse, while others retract their reports because of safety concerns, complex reporting processes, cultural taboo and stigma. Some may even consider abuse a private or family matter. Non-citizens face obstacles, such as limited language support in hotlines and access to the judicial system.

Even when cases are reported, some police, medical and welfare officers are inexperienced or trained inadequately to handle child abuse.[43] This has, unfortunately, led to dismissals without further action, thus perpetuating the cycle of abuse.

Furthermore, the public and media's effort to raise awareness by posting visual evidence on social media endangers the involved children and contravenes Section 15 of the Child Act as well as Section 14 of the Evidence of Child Witness Act 2007 (Act 676).

Despite the presence of various hotlines, shelters and one-stop crisis centres, Malaysia severely lacks social workers, with only one social worker for every 8,576 citizens.[44] This workforce gap overstretches and weakens the current childcare services and welfare of the nation. The 14-year delay in tabling the Social Work Profession Bill (recently postponed again) disappointed many advocates.[45]

Social workers are crucial to hold society together, protect children from violence, promote social justice and address inequalities. This calls for an urgent reconsideration to strengthen both services and societal responsibility towards children.

IV. Financing

Although the government offers subsidies and tax reliefs for childcare expenses, private Taska are often not an option for low-income families. Affordability concerns mean that some resort to government-run Taska while others forgo enrolling their children in early childhood care and education altogether. Missing out on the foundational years of learning leads to an educational lag for these children, resulting in them being left further behind in their learning, development and employment opportunities.

From the childcare provider's perspective, apart from having to manage rising operating costs, the challenge within the local councils is the varying leg-

islation by area, which makes it difficult for Taska to continue operating at a profit. As proposed in a meeting with Department of Town and Country Planning (Jabatan Perancangan Bandar dan Desa) and district-level local councils, Taska, Tadika, and pusat jagaan (care centres) should be classified as social industries under category A. This category includes houses of worship, community centres and other similar establishments. This way, there will be minimal fees associated with converting residential buildings to commercial ones.

NGOs that provide care services for children, including shelters or alternative learning centres, often face the perennial issue of a lack of funding as they are largely donor dependent. This contributes to understaffing and working under greater constraints, resulting in higher rates of burnout. Separately, the lack of investments in training and technology in the care for children is a major gap. For example, efforts to make assistive technology affordable and accessible for children with disabilities are how technology could drive the care economy.

V. Role of public, private and voluntary sectors

The public sector plays the leading role as policymaker, regulator and funder to safeguard the best interests of children in various care settings. With the growing demand for care, limited resources and capacity, the private sector is increasingly playing a significant complementary role as care provider, funder and innovator, filling the gaps that the public sector could not address adequately. However, care services by private operators are often out of reach of low-income families. These services are also mostly concentrated in urban areas and inaccessible to those living in rural and remote areas.

The voluntary sector plays a critically supportive role in providing care and support for children and their families, advocacy and whistleblowing for violation of children's rights. This sector plays an important role in reducing inequalities to improve the wellbeing of children, particularly those from disadvantaged communities.

Ensuring that the needs and rights of every child are respected and upheld is a shared responsibility. Partnerships between public-private-voluntary sectors are necessary to meet the present and future care needs of our children. Hence, it is imperative that licensing, standards of care, qualification of staff and care personnel, as well as monitoring mechanisms, are collectively designed, implemented, enforced and evaluated regularly across all sectors for the best interests of children.

VI. Children in poverty

In the interest of leaving no child behind, this section highlights NGO-run preschools and alternative learning centres for marginalised children in Malaysia, including Orang Asli, stateless and refugee children.

These centres – often donor funded and managed by non-profit organisations or faith-based groups – address barriers of financial limitations and lack of documentation that keep them out of mainstream education. Without these opportunities, these children face exclusion in education, missing out on qualifications, social connections, support and risk detention, in some cases. The efforts of three NGOs will be featured.

SUKA Society supports Orang Asli and Orang Asal children through the Empowered2Teach programme, preparing them for primary education in their village preschools. Their unique mother tongue teaching tool (alat mengajar bahasa ibunda) was created by Orang Asal teachers and linguistic experts as an early childhood educational resource.[46] Available in Semai, Jakun and Temiar, this contextualised tool offers fun, hands-on learning activities while preserving indigenous knowledge and empowering indigenous educators and their communities.

Iskul Sama DiLaut Omadal (Bajau Laut Omadal School) provides literacy training for stateless Bajau Laut children in Sabah's Pulau Omadal, Semporna. These children lack access to formal education due to their undocumented status.[47] Established in 2015 with the support of local authorities, Iskul uses a community participatory approach in providing basic education and organising sports, cultural and health activities.[48] Despite intimidation and threats, Iskul underscores the need for the government to seriously consider protecting the rights of these children to study in safe spaces. The statelessness crisis in Sabah is no doubt a tough call and urgently warrants a wise, decisive and compassionate approach to uphold the rights-based needs of these children.

The United Nations High Commissioner for Refugees (UNHCR) reported that only 34% of 53,225 refugee children in Malaysia have access to informal education through alternative learning centres.[49] ElShaddai Centre supports refugees, asylum-seekers and stateless children through inclusive learning opportunities from preschool to high school.[50] Preschools are established within these communities for easy access, removing the transport cost barriers. Despite being resource-intensive, ElShaddai's efforts reflect a commitment to providing continuous, rights-based education for these vulnerable children.

Rather than a burden, these NGOs demonstrate that the deprivations these children experience present an opportunity for nation- and capacity-building. Hence, the Malaysian government, together with the private sector and civil

society, is urged to support marginalised children's rights as affirmed in the UNCRC by promoting a rights-based, inclusive and quality education for all children in Malaysia.

6.4 Case study: care for traumatised, neglected and vulnerable children

This section aims to provide an example of the experiences and challenges faced by providers of childcare services in Malaysia. To achieve this, the authors interviewed an NGO, which requested anonymity, in August 2024.

The NGO supports traumatised, neglected and vulnerable children, primarily referred by JKM through court orders or guardians of children with behavioural issues. Details of its experiences are broken down below:

I. Services

The NGO offers the following services: 1) residential care in three different homes categorised by sex and age groups; 2) an after-school programme for latchkey children; 3) a multiple-aid programme providing monthly grocery supplies, and; 4) family counselling and support groups for children in their care (FBC).[51]

II. Facilitating family reconciliation

In efforts towards deinstitutionalisation, its homes aim to reunite the children with their families within two years. Challenges include complex parental behavioural issues exacerbated by their own challenges and stressors.

III. Multidisciplinary case management

To aid the children's recovery from the trauma of abuse, the home adopts a multidisciplinary case management approach, collaborating with licensed counsellors, psychologists, therapists, social workers and healthcare professionals. This is crucially important, considering institutionalised children are at up to seven times more at risk of mental and behavioural problems.[52]

IV. Journeying with the children

The NGO emphasised focusing on children's interests, celebrating their strengths and supporting their character development, and building coping skills and resilience. These are essential for when the children transition back home or move to new environments like university or employment.

V. Staff reward and wellbeing

Acknowledging the demands on caregivers, the NGO intentionally prioritises staff wellbeing through rewards, rest and leave days to appreciate the team and mitigate burnout. These demonstrate care for staff even as it invests heavily in caring for its high-needs children.

VI. Exploring new pathways

Staff retention can be challenging, as the NGO faces funding constraints and rising operating costs. To address this, it is exploring alternative funding models and income streams, such as reaching younger donors on TikTok, forging partnerships with universities, offering volunteer placements and legacy giving.

VII. Hopes

The NGO highlighted the need for government agencies, including JKM, to conduct field visits to shelters, including those run by faith-based groups. This will be beneficial for the agencies to understand better the ground realities and strengthen synergistic partnerships in supporting vulnerable children.

6.5 Recommendations

Our recommendations are divided according to the different scopes and themes.

I. Legislation and regulations

In terms of legislation and regulations, registration of childcare centres is crucial to safeguard the children, their caregivers and ensure quality of care. Hence, for willing parties currently operating without a licence, advisory services and a grace period to facilitate registration and compliance with the necessary requirements by technical agencies and local authorities are warranted. Vigilant surveillance and enforcement remain important to identify and act against unregistered care centres under the Child Care Centre Act 1984 in the interest of the children as well as their caregivers.

Another key focus should be to prioritise and expedite the passing of the Social Work Profession Bill. This will accord formal recognition of the social work profession and affirm its value, establish professional regulation and development, including the requirement for qualifications and competencies. Malaysia will do well to follow the footsteps of our regional neighbours, such as Singapore, Indonesia, the Philippines, and Thailand, which recognise the value of social workers and passed relevant legislation.[53] This will not only benefit children in need of protection but the wider care economy ecosystem, including vulnerable older persons, children with disabilities and marginalised communities.

II. Workforce

When considering the childcare workforce, promoting clear career pathways at the national level outlining graduate training, qualifications and a competitive pay structure to ensure the professionalisation of child caregivers and educators must be prioritised. This would involve a cross-ministerial effort among the Higher Education Ministry, Ministry of Human Resources, Ministry of Economy and MWFCD. Moreover, it will outline the required competencies, skills and knowledge needed, besides helping to redefine career structures, training pathways, job titles, compensation and benefits. These are fundamental to raising the profile of childcare-related professions, standards, quality of care and education.

For those currently in the workforce, mandating minimum qualifications and compulsory training within specific timeframes to upskill the current work-

force are important. Incentives, such as continuous professional development points, as well as benefits like e-wallet rebates and professional advancement, should commensurate with these efforts. Here, fostering and leveraging on public-private partnership grants, sponsorships and scholarships will be valuable to upskill and nurture competent and compassionate childcare professionals.

III. Child protection

To demonstrate commitment towards child protection, there is a need to allocate resources for systematic and mandatory specialised training on child protection, child rights and SOP for first responders, including police officers, healthcare professionals, JKM officers and teachers. This involves mandating child safeguarding training, policies and reporting procedures in all educational and care settings.[54] In addition, given its resource and manpower constraints, JKM should consider working closely with civil society organisations, the private sector and academia to support child-protection efforts. This may entail harnessing AI for surveillance of online sexual harm, developing capacity building courses to improve detection, reporting of child abuse cases and supporting victims.

At the community level, efforts to design and conduct contextualised community awareness programmes on child abuse and make multilingual audiovisual resources available are recommended. The Women's Centre for Change in Penang has led the way in developing excellent resources in English, Bahasa Malaysia, Mandarin and Tamil.[55] Such resources should be developed for vulnerable minority communities, particularly the indigenous, refugee and migrant communities. This necessitates engaging interpreters, storytellers, illustrators and content creators.

IV. Financing

From the financing aspect, public-private-voluntary sector partnerships remain vital to drive and incentivise investments, training and innovations that will drive the expansion of the care economy for children. These can range from skills-based training for childcare providers to innovative funding models and technology innovations that reduce disparities between urban and rural areas. These would be mutually beneficial for caregivers, children and their families.

The reclassification of Taska, Tadika and pusat jagaan to category A as social industries should be seriously considered. This will ease the high operating costs for childcare providers and potentially reduce childcare costs that will benefit families.

Affordability and accessibility of quality and trusted childcare sits at the heart of women's participation in the labour force. Encouraging such provision of affordable, strategically located and regulated childcare, whether community based or workplace based, will create an enabling environment for women to continue to contribute to the economy while ensuring that their dependents are cared for. Here, multisectoral partnerships, forward-thinking planning and judicious budgeting at the district and neighbourhood level are foundational to anticipate and cater to childcare needs. For low-income families, targeted subsidies for childcare with a graduated approach is proposed to ease the costs of childcare and encourage women to remain employed.

6.6 Conclusion

It is heartening that the childcare needs of working mothers and the importance of quality care for children have garnered national attention. The government has pledged to provide the necessary support for women to remain or return to work, as indicated by the prime minister's speech during the Mid-Term Review of the 12th Malaysia Plan, 2021-2025. This is in line with the government's aspirations to reach the targeted 60% women LFPR within a decade.

This exercise on evaluating the provision of care for children in Malaysia has been eye-opening. More importantly, reforms and affirmative actions to improve the legislative framework, professionalise the workforce and care for workers' wellbeing, strengthen child-protection services, secure sustainable financing and accelerate technology adoption are critical enablers to boost the care economy for children. These will create positive ripple effects in improving the quality of life and safeguarding the children in our nation, their caregivers and their families.

7

Care of persons with psychosocial disabilities

Cost, urban-rural service gaps among challenges confronting families, caregivers

Andrew M Chandrasekaran
Laura Kho Sui San

7.1 Introduction and background

I. Psychosocial disabilities and stigma

Psychosocial disabilities are not defined by a specific diagnosis. Instead, they refer to the barriers that limit a person's ability to participate fully in everyday life.[1] These disabilities arise when individuals living with mental health conditions – such as schizophrenia, bipolar disorder or major depressive disorder – face societal barriers that restrict their equal access to resources and opportunities. Those affected often require support to overcome these challenges and achieve social inclusion.

Despite growing awareness of mental health, many individuals continue to face stigma, discrimination and limited access to holistic care. National disability organisations often overlook these challenges, while the term "psychosocial disability" is rarely used outside human rights, disability and international non-governmental organisation (NGO) circles. As a result, affected individuals might experience additional stigma, even in places meant to support persons with disabilities.

This makes it harder for them to access services or receive quality care. The issues stem from broader misconceptions about mental health and disabilities, which can leave affected individuals feeling even more isolated as well as marginalised. Changing these attitudes is critical to ensure that individuals with psychosocial disabilities receive care that respects their rights and dignity.

As Malaysia works towards a more inclusive society, there is a pressing need to address the existing gaps in care for persons with psychosocial disabilities. Collaboration between the public, private and non-governmental sectors is essential to build a system grounded in a rights-based approach. This ensures that no one is left behind, whether in urban centres or rural, underserved communities. The care of persons with psychosocial disabilities should be seen as a shared responsibility across all sectors.

Unlike aged care or childcare models, the support needs of individuals with psychosocial disabilities are diverse and complex, varying across life stages and requiring different levels of support. Mental illnesses often involve periods

of relapse and remission, necessitating a flexible and measured approach to care that adapts to evolving needs over time. This could include support for activities of daily living, job coaching, psychological support or medication management

For elderly individuals with serious mental illnesses, their needs can be even more complex. They often need both psychiatric care and support for age-related issues, especially those with dementia who require specialised support.

II. Historical context of mental health services

Historically, before effective psychiatric medications became available, mentally ill patients were incarcerated in asylums, a legacy of the British colonial administration. The first psychiatric hospital, Central Mental Hospital, was established in Tanjung Rambutan, Perak, in 1911 with 280 beds.[2]

In the 1920s, two more psychiatric hospitals opened in Sabah and Sarawak, followed by Tampoi Mental Hospital in Johor in 1935.[3] These facilities operated with institutionalised care, where patients – often with chronic and untreatable mental illnesses – lived in poor conditions. However, around the time of Malaya's independence in 1957, the "deinstitutionalisation" movement was gaining momentum globally, shifting mental health care from long-term psychiatric facilities to community-based services.[4]

In Malaysia, this process began in the 1970s with the decentralisation of mental health services to tertiary hospitals and primary care.[5] For this transition to be successful, former institutional residents must have access to good quality community-based services, including evidence-based clinical care and social services, such as housing, employment and support for community reintegration. Long-stay spaces remain necessary for some, but these should be smaller, community-integrated homes rather than large institutions.[6]

When not accompanied by sufficient financial, structural and strategic investment in community-based services, patients are often discharged into the care of unprepared families as well as carers who lack the training and resources to manage severe mental illnesses. This problem is even more pronounced in remote areas. Many families preferred their relatives to stay in institutions because of stigma, misconceptions about mental illness and societal pressures.[7] Families and caregivers also face stigma by association, adding to their stress.[8]

Without proper planning, deinstitutionalisation could result in negative outcomes, including homelessness or reinstitutionalisation in places like prisons.[9] In Malaysia, some patients were not successfully transitioned to community care and remained in state-run institutions, such as Hospital Bahagia, Ulu Kinta, Hospital Sentosa, Kuching and Hospital Bukit Padang, Kota Kinabalu.

III. Regulatory gaps in mental health and psychosocial care

The Mental Health Act 2001 (MHA 2001), along with the Mental Health Regulations 2010, introduced a shared responsibility for mental health services across the public and private sectors. MHA 2001 provides detailed guidelines for three types of facilities: psychiatric hospitals, psychiatric nursing homes and community mental health centres. It also safeguards patient rights and promotes decentralised services like mental health teams and psychiatric homes. While the private sector is included, it receives less emphasis.[10]

The act defines psychiatric nursing homes as intermediate care facilities that provide accommodation, nursing and rehabilitative care for individuals suffering from or recovering from mental illnesses. Private facilities must comply with both MHA 2001 and the Private Healthcare Facilities and Services Act 1998 but are not covered by the Care Centres Act 1993, creating regulatory gaps that could affect the quality of care in these settings.

Psychiatric nursing homes must register with the Health Ministry's (MOH) Private Medical Practice Control Section and adhere to its regulations. However, a recent newspaper article highlighted that many facilities offering psychiatric care are instead registered as general care homes with the Department of Social Welfare (Jabatan Kebajikan Masyarakat), leading to inconsistent oversight.[11]

The rise in illegal psychiatric nursing homes has raised concerns about human rights violations in unregistered or improperly registered centres. MOH has also been urged to review and regulate these facilities to meet global standards in psychiatric care. A proposed solution is the introduction of a board of visitors, similar to those in hospitals, consisting of community members. This would enhance monitoring and encourage community involvement in providing holistic care for residents.[12]

7.2 Framing psychosocial care as a shared responsibility

The care of individuals with psychosocial disabilities is a shared responsibility across the public, private and NGO sectors. Each plays a crucial role in addressing the broader social, cultural and economic factors influencing mental health. Effective collaboration among public health services, private entities, NGOs and community networks is essential to delivering comprehensive, rights-based care that enables individuals with psychosocial disabilities to lead fulfilling lives.

In this model, the public sector provides the foundation through policy frameworks, legislation, oversight and funding. The private sector enhances service capacity by offering specialised care, while NGOs focus on advocacy, community engagement and non-clinical support services that address the social factors that influence mental health.

This collaboration ensures a continuum of care that is both medically effective and socially responsive. It supports a wide range of services, from acute and residential care to community-based support, housing, and employment services, all of which contribute to person-centred care that respects individual rights and autonomy.

At the core of this shared responsibility is a rights-based approach, emphasising dignity, inclusion and empowerment. Aligned with international standards like the Convention on the Rights of Persons with Disabilities, this approach ensures equal access to services, promotes community-based care and eliminates discrimination. All stakeholders – public, private and NGO – are committed to practices that uphold respect, empathy and non-discrimination.

I. Public sector's contributions

The public sector remains the primary provider of mental health and psychosocial services in Malaysia. MOH oversees psychiatric hospitals, community mental health centres (MENTARI), multidisciplinary community psychiatry teams and mental health services integrated into general hospitals and klinik kesihatan (health clinics). These services form the backbone of the country's mental healthcare, offering a wide range of support from acute psychiatric care to community-based interventions that promote recovery and social reintegration.

MENTARI centres are a key model of decentralised mental health care.[13] They provide psychiatric assessments, psychoeducation, daycare activities, skills training and peer support within a community-based framework. Currently, there are about 33 MENTARI centres nationwide, some operating through public-private-NGO partnerships.

However, the public sector faces significant challenges, including resource constraints, workforce shortages and limited-service capacity.[14] There is a pressing need for more mental health professionals – psychiatrists, clinical psychologists, counsellors, psychiatric social workers, community psychiatric nurses and support workers – to ensure services are both accessible and of high quality, especially in rural and remote areas.

II. Private sector's role

The private sector plays a complementary yet pivotal role in meeting the psychosocial care needs that might not be addressed fully by public services. This includes private psychiatric hospitals and clinics that offer both outpatient and inpatient care as well as psychiatric nursing homes providing residential services. The private sector can help fill critical gaps left by public services, especially in providing specialised community-based rehabilitation services and recovery support for individuals with psychosocial disabilities. These services also reduce wait times, offering faster access to care.

However, affordability remains a significant barrier, as private care is often too expensive for many families. Ensuring that private sector services are both accessible and affordable is crucial to creating a more inclusive mental health system. To ensure high-quality, person-centred care that supports long-term recovery, it is vital to establish standards for care quality, ethical practices, and professional qualifications, along with robust regulatory mechanisms for ongoing monitoring and oversight.

III. NGO and community-based services

NGOs and community-based organisations play a critical role in providing innovative care models (e.g. the clubhouse model) and advocacy for individuals with psychosocial disabilities. They are essential in filling gaps in community-based support services. Common offerings include peer-led support groups, psychoeducation for families and caregivers, supported employment, and social reintegration activities. By engaging directly with communities, NGOs are well positioned to bridge service gaps as well as tackle the stigma and discrimination faced by individuals with psychosocial disabilities.

Examples include the Malaysian Mental Health Association (MMHA) and Mental Illness Awareness and Support Association, both of which run peer-led support groups for caregivers and individuals with psychosocial disabilities, providing a safe space to share experiences and seek support.[15] The Mental Health Association of Sarawak operates a group home in Kuching, where residents live independently under the supervision of a centre manager.[16] All three organisations also offer counselling services at free or affordable rates for B40 communities.

Public-private partnerships, where NGOs collaborate with government agencies and private providers, have been effective in delivering community-based mental health services. These partnerships allow for sharing resources and expertise, creating a more integrated and comprehensive service model. For instance, some MENTARI centres collaborate with NGOs to provide both medical and

psychosocial interventions, extending care beyond traditional healthcare settings. However, resource limitations mean they often operate primarily in urban centres, leaving the needs of individuals in rural or remote areas largely unmet. In addition, the lack of stable and sustainable funding limits their ability to expand services and reach more communities.

Addressing psychosocial care as a shared responsibility across sectors not only improves service delivery but also upholds the fundamental human rights of individuals with psychosocial disabilities. This multi-sectoral collaboration is fundamental to creating a holistic care ecosystem that supports recovery, social inclusion and the ability for individuals to live meaningful lives within their communities.

7.3 Framing future directions for psychosocial care

In Malaysia, care workers and social workers contribute significantly to community-based care, especially in the absence of extensive institutional support. They fill critical health and social services gaps by helping individuals maintain dignity, independence and quality of life. With the population rapidly ageing, care workers' roles have gained increasing attention. Similarly, social workers are at the forefront of tackling complex social issues, such as poverty, mental health stigma, family violence and child protection.

Both professions are critical to promoting social justice, enhancing wellbeing, reducing inequalities and fostering social inclusion in Malaysia. In a multicultural society with diverse economic backgrounds, caregivers and social workers are essential in bridging the disparity in access to health and social care services. They are instrumental in connecting service users and their families to supportive community mental health services. Their familiarity with individual family situations helps them navigate through stigma, ignorance and reluctance to access appropriate care. This is key to achieving the aim of inclusion of persons with psychosocial disabilities into their local communities.

However, specialised mental health care workers and psychiatric social workers are significantly lacking in Malaysia, while the unmet needs of persons with psychosocial disabilities grow exponentially. As the nation continues to shift towards a more community-based approach, the focus must move beyond service provision to develop comprehensive training, support systems and ethical frameworks that empower both formal and informal caregivers.

7.4 Key requirements for care and social workers

I. Knowledge

Care workers and social workers need to have a broad understanding of what constitutes psychosocial disabilities. Social workers, particularly, need to be familiar with the existing mental health frameworks, including the relevant provisions under MHA 2001, to ensure optimum accessibility to mental health services as well as to prevent potential abuses in the system. One area of concern is coercion in treatment and involuntary hospital admissions of persons with psychosocial disabilities.

A deep understanding of legal and ethical standards in the context of the Malaysian health and social care systems will lead to a robust, high-quality provision of social work services. Care workers, who are often non-citizens, may need to have additional cultural competence in carrying out their responsibilities. Moreover, social workers need to have a high degree of cultural sensitivity in navigating through the challenges of clients in a multicultural society that is Malaysia.

II. Skills

Undoubtedly, specialised yet practical communication skills need to be incorporated into the service provision of caregivers and social workers working with persons with psychosocial disabilities and their families. Additionally, social workers would need to be empowered to conduct appropriate assessments and evaluations. Familiarity with crisis intervention, problem solving, trauma-informed care and case management is also essential.

Social workers, who are familiar with advocacy principles, might need additional knowledge about the advocacy needs of the community with psychosocial challenges. Navigating these demands, caregivers and social workers need to know the importance of self-care and resilience.

III. Values

The inherent values of empathy and compassion and a non-judgmental attitude in a social worker or caregiver cannot be emphasised more. A deeply ingrained commitment to social justice and respect for the dignity of persons with psychosocial needs will contribute to the empowerment and inclusion of such a vulnerable

community. Confidentiality and trust are the other components that make serving persons with psychosocial disabilities more robust.

IV. Standards required to ensure quality care and services

Training mechanisms must be standardised, leading to professional qualifications and certification. The opportunity for professional qualifications must be socialised to attract more applicants to the training programme. Such training must lead to a registrable qualification with a professional body.

Care delivery standards in mental health caregiving and psychiatric social work must also be established. Ethical and service delivery standards must be monitored by an independent body that could incorporate a complaint and redressal mechanism.

Such a body can expand its terms of reference to include monitoring and evaluating services and providing input into policies and laws regarding caregiving and social work. It also needs to collaborate with other key stakeholders in the industry.

7.5 Challenges for social work organisations

For care workers, there is a lack of formal recognition and support. They also face emotional and physical burdens because of long hours and a lack of respite care. Additionally, there is financial strain as many are unpaid or underpaid.

As for social workers, there is the challenge of limited resources and funding in public sectors, leading to burnout. The public lacks awareness or understanding of the profession. Legal and bureaucratic challenges – particularly in dealing with sensitive populations such as persons with psychosocial disabilities, children or refugees – may be a significant obstacle.

Broadly, these challenges can be categorised into structural, social and operational challenges.

Table 7.5.1. Challenges faced by social work organisations

Structural	Operational	Social
• Complex regulations regarding the practice of mental health care workers • Lack of clear policies related to practices of psychiatric social work and mental health care work • Limited infrastructure for service provision • Lack of technological comprehension by social workers to maximise tech-driven services • Financial challenges in building appropriate service infrastructure	• Lack of human resources in social work and care worker services • Fragmentation of social work services among stakeholders • Lack of collaboration and partnerships between formal and non-formal stakeholders • Dependency on political and economic stability as well as agenda of government of the day	• Poor public perception and awareness of role of psychiatric social workers and mental health caregivers • Cultural barriers that limit the optimal utilisation of human resources in psychiatric social work and mental health care services

7.6 Strategies and recommendations

Advocacy and policy reforms need to be initiated by the relevant government agencies, taking a multi-stakeholder approach, such as encouraging partnerships between government agencies and NGOs, to boost resources. Funding has been a major obstacle in providing such grassroot services – thus, diversifying funding sources from federal, state government as well as independent donor agencies is imperative.

Capacity building of mental health care workers and enhancement of social work to specialised psychiatric social work needs to be considered. This includes educational and training programmes to upskill caregivers as well as social workers, with a focus on mental health, trauma-informed care and elder care. Essentially, social work should be integrated with our healthcare and education systems. Simultaneously, public-awareness campaigns and community engagement to create the push factor towards meeting the needs of persons with psychosocial disabilities must be socialised.

An example of an effective community engagement programme is MMHA's caregiver programme. In the initiative, families and caregivers are gathered through local focal points in selected areas throughout the country. They are given caregiver information on support mechanisms, relapse prevention and advocacy skills.

There is also an emphasis on the prevention of burnout among caregivers, who also moderate sessions through the sharing of caregiver experience. These sessions are supervised by a mental health professional from a government hospital. This initiative aims to empower caregivers and service users by applying the concept of "nothing about us, without us".

This initiative helps community-based services to address existing gaps in care for persons with psychosocial disabilities. It is universally recognised that the family unit and, by extension, the community, is the best "therapeutic milieu" for effective care and inclusion of persons with psychosocial disabilities. Good community care not only facilitates early detection of recurring symptoms but also support for individuals on the verge of psychological decompensation, hence preventing relapse.

This also helps vulnerable individuals function better in social and occupational domains, enabling them to claim full citizenship as members of society living in dignity. Furthermore, it prevents the "revolving door" phenomenon at tertiary care centres, which not only adds to the cost of service to the nation and families but also delays reintegration of decompensated individuals into society. Thus, the role of mental health care and social workers is key to the success of community-based mental health services.

Nonetheless, community-based services are not without challenges. Stigma, shame and belief in alternative, non-evidence-based treatment are predominant in close-knit communities irrespective of the level of urbanisation. However, urban settings provide some degree of "anonymity" in accessing mental health services. Families' preference for seeking formal treatment outside their immediate communities is a major challenge in ensuring insight-oriented care within the community.

Poverty and mental illness exist in a vicious cycle. Urban poverty, as experienced in the B40 category, has demonstrated that despite geographic proximity to mental health services, economic pressures and weight of informal caregiving play a part in increasing the risk of mental illness.

7.7 Conclusion

Addressing the needs of individuals with psychosocial disabilities necessitates a comprehensive approach that involves shared responsibility across the public, private and NGO sectors. It also calls for a stronger emphasis on building a knowledgeable, skilled and values-driven workforce that can meet the diverse needs of individuals with psychosocial disabilities. A community-based approach that supports both individuals with disabilities and their caregivers is crucial.

This can be achieved through a combination of strategies, such as: 1) formal recognition and support for caregivers; 2) strengthening social work practices; 3) fostering partnerships; 4) investing in education and training; 5) expanding the role of social work, and; 6) leveraging on technology, such as mobile apps in the operational infrastructure of psychiatric social work and mental health care services. By implementing these recommendations, we can work towards a future where individuals with psychosocial disabilities can lead fulfilling lives within their communities.

7.8 Case study: realities of the B40 communities caring for those with psychosocial disabilities

The two following case studies highlight the lived realities of B40 communities – the bottom 40% of income earners – and the significant challenges they face accessing psychosocial care, such as financial strain, stigma and discrimination, and lack of awareness about resources.

I. Urban context in the peninsula

Psychosocial care is often put on the backburner to compensate for basics like housing, food and transport. Alternatively, caregivers might need to reduce their working hours or quit their jobs to provide full-time care for their loved ones. The gig economy also seems to be the preferred source of income for urban B40 families, which could result in a loss of income during periods of stress, such as relapse of a loved one with psychosocial disabilities.

The financial pressures of an urban B40 family can be highlighted in the case of Eddie – a 30-year-old unemployed man diagnosed with chronic schizophrenia living with his parents in a low-cost flat in Shah Alam. Both parents work to make ends meet and cater for Eddie's needs and his younger sister, who has Down's syndrome. His parents used to drop Eddie off for psychosocial rehabilitation at the MMHA Day Care Centre. However, his parents could not ensure Eddie's consistent attendance because of time constraints and transportation costs. Eddie frequently relapsed despite the klinik kesihatan being situated a few kilometres away from his house from where he collects his monthly supply of psychotropic medication.

Furthermore, psychosocial disabilities (indeed, mental healthcare in general) remain stigmatised in the B40 communities. Persons with such disabil-

ities and their caregivers face isolation and discrimination because of the lack of awareness on mental health issues, which are perceived to be a flaw or attributed to spiritual causes. These prevent open conversations and support and could also lead to alternative spiritual or religious treatments that leave the disability untreated. The stigmatisation of mental health could also impact on the employment prospects of both persons with psychosocial disabilities and caregivers, given the lack of workplace support like flexible work arrangements to accommodate their lived realities.

The lack of awareness is not just in terms of the B40 community itself but also in terms of the resources available. This includes aid, community programmes and NGOs that offer a variety of alternative support at subsidised rates. MMHA's caregiver programme and its tele-counselling services are prime examples. Information might also be difficult to disseminate, as both urban and rural B40 families live in underserved areas where mental health care and support are either scarce or unavailable. Moreover, in instances where families do benefit from government aid or welfare programmes, the support often falls short in addressing the specific needs of persons with psychosocial disabilities and caregivers.

Eddie's case highlights common challenges faced by urban B40 communities vis-à-vis the lack of awareness on mental health and psychosocial disabilities, such as a poor understanding of the course of mental illness and possibly lack of mental health trained services at the local klinik kesihatan. For example, a condition like schizophrenia requires long-term medication that must be adjusted depending on the patient's condition.

Eddie would have to be accompanied by his parents for frequent consultations that could often extend beyond the klinik kesihatan, particularly if his medication has to be adjusted. Given the costs of these visits, they could be infrequent and with repercussions for both Eddie and his parents. His condition could worsen and his parents could lose the opportunity to educate themselves more about his condition. Finally, the medications available in public healthcare are mostly commonly used drugs. Therefore, access to newer or more expensive medications for conditions like schizophrenia would mean out-of-pocket payment for Eddie's parents, adding to their financial strain.

II. Rural B40 context in Sarawak

In Sarawak, the B40 population faces substantial difficulties in accessing psychosocial care, particularly in rural and remote areas. With a land mass equivalent to the peninsula (excluding Negeri Sembilan), Sarawak has a population density of just 23 people per km, compared with the national average of 99 per km.

Almost half of Sarawak's population (45.3%) lives in rural areas – nearly double the national average – making access to psychosocial support and services both difficult and costly for many who live far from government clinics.[17]

In addition to geographic barriers, Sarawak's population comprises of more than 40 sub-ethnic groups, each with a distinct culture and language. This diversity requires psychosocial services to be culturally sensitive and adaptable to the population's unique needs.

III. Geographic isolation and service gaps

Access to specialised healthcare in rural and remote rural Sarawak is challenging. To illustrate, the 2019 Household Income and Basic Amenities Survey indicates that 73.5% of its households lived within 5km of a public health facility but this figure dropped in 31 out of 40 districts. In Sebauh, only 27.6% of households met this standard.[18]

Psychiatric services in Sarawak are concentrated in cities and towns, with only eight departments scattered across Kuching, Serian, Sri Aman, Sibu, Bintulu, Miri and Limbang. These departments offer visiting services to district hospitals every two weeks to two months. However, Kapit, Mukah, Betong, Saratok and Lawas remain underserved, lacking resident psychiatric teams despite growing populations. The state has four MENTARI community mental health centres focusing on work-based rehabilitation and recovery. Gaps in rural care are partially addressed by visiting community psychiatry teams that provide home visits to ensure continuity of care for those with psychosocial disabilities.[19]

IV. Economic pressures on families

For B40 families in rural Sarawak, geographical isolation makes access to specialised care difficult. In rural and remote rural areas, the nearest psychiatric services may be hours away, requiring costly and time-consuming journeys that many families cannot afford. Without regular medical care, they are left to manage their loved one's complex needs alone.

Limited financial resources, compounded by the high costs of transportation and care, leave families trapped in a cycle of choosing between caring for their loved ones at home and facing financial instability by seeking help. Without proper support and rehabilitation services – compounded by stigma – individuals with psychosocial disabilities struggle to find employment, further worsening a family's financial situation.

V. Cultural barriers and mental health stigma

Cultural factors also play a significant role in limiting access to care, especially in rural communities where mental illness may be seen as taboo or something to be addressed through traditional healing rather than medical intervention. While these practices may offer emotional comfort, they rarely address the underlying mental health conditions, worsening an individual's situation as families feel powerless to seek formal care.[20]

In rural areas, mental health issues are often viewed as spiritual disturbances or as a source of shame, causing families to hide the conditions of their loved ones to avoid judgment or social rejection.[21] This stigma discourages many from seeking help, widening the care gap for those with psychosocial disabilities.

VI. Weight of informal caregiving

In the absence of formal support structures, family members – often women or elderly relatives – bear the full responsibility for caring for individuals with psychosocial disabilities in rural Sarawak. With no formal training, these caregivers are tasked with managing challenging behaviours, providing emotional support and ensuring the safety of their loved ones, all while managing their own household responsibilities. The physical and emotional toll on caregivers is immense, with many reporting feelings of burnout, helplessness and isolation.[22]

Without professional support or respite care, caregivers often feel trapped, unable to leave their homes because of the constant supervision required. The lack of self-care time worsens the strain on families. The situation becomes more complicated when a primary caregiver – often a parent – dies, leaving the care to a sibling or extended family members.[23]

VII. Existing informal and community support systems

Local religious and cultural institutions play an important role in providing support within the community. Churches, mosques and traditional kampung networks offer social and emotional support to families affected by mental health challenges. These structures help reduce isolation for caregivers and individuals with psychosocial disabilities but they cannot replace the need for professional care.

VIII. Conclusion

For B40 families living in rural Sarawak, the reality of caring for someone with a psychosocial disability is shaped by isolation, economic hardship, cultural stigma and the heavy burden of informal caregiving. These families, already living on the fringes, urgently need psychosocial support services to ease the burden on caregivers and help their loved ones reclaim a life of dignity.

While the geographic, economic and cultural barriers to psychosocial care in Sarawak's rural B40 communities are significant, they are not insurmountable. Mobile health services, community-based mental health programmes and culturally sensitive awareness campaigns can bridge the care gap. However, solutions must be tailored to local needs and cultural sensitivities, as what works for urban B40 communities might not suit rural Sarawak. Collaboration between the government, the private sector and NGOs is essential to integrate formal and informal care systems, ultimately improving the quality of life for the most vulnerable in rural Sarawak.

8

Case for professionalising social care

Childcare, elderly care have head start meeting market demands

Teoh Ai Hua

8.1 Introduction

The demand for social care is rising because of interconnected factors arising from demographic shifts and changing family dynamics. These factors are reshaping societal needs and challenging existing care structures to adapt and evolve.

The increase of an ageing population in Malaysia means more individuals require care as they live longer. Simultaneously, changing family structures – such as nuclear families and geographical mobility – reduce the availability of informal caregiving for children, older persons and those living with dependents. These shifts place pressure on the formal social-care services, which might have grown over the years but are neither sufficient nor mature to meet demands.

Additionally, the prevalence of complex health needs, including comorbidity and mental health conditions, further drives demand for a competent and skilled workforce. Meanwhile, funding models vary – the rising costs of care compounds financial pressures on individuals, families and the government.

These interrelated challenges highlight the critical need for a comprehensive framework that supports the care ecosystem. Balancing affordability with quality care provision remains a delicate task. Effective integration between the health and social-care systems is essential, as is finding the right balance between preventive and reactive care approaches. Social care is not only a response to growing demand but also a foundation for society's wellbeing.

The care economy is a crucial concept that encompasses the production and consumption of goods and services necessary for the wellbeing of care-dependent groups. For the social care sector to thrive as an industry, we need to focus on the market, which encompasses service providers, workforce and users.

Despite the development of Malaysia's care economy, the sector continues to face significant challenges. Issues such as low wages, workforce shortage and inconsistent quality in care provision hinder its progress. Additionally, the uneven development across different sectors of care exacerbates disparities, leaving some groups without adequate support. Addressing these barriers is essential for building a more resilient and equitable care system.

Therefore, this paper aims to: 1) explore the concept of the care economy and roles of different service providers from the social welfare perspective; 2) ex-

amine the current state of its workforce and its related training and regulations; 3) discuss gaps; and 4) propose ways forward to develop a viable social care industry.

8.2 Key themes of care economy

This section explores some relevant themes of the care economy in Malaysia. As a start, it would be beneficial to understand it from a larger social welfare context where social care is normally situated.

I. Mixed economy of care

"Welfare" is a broader concept that refers to an overall condition emphasising on happiness, contentment and the wellbeing of individuals, communities or entire nations. While welfare is often seen from financial or material wellbeing perspectives, it also extends to mental, emotional and social aspects.

In contrast, social welfare typically denotes government-funded programmes designed to assist society. Social welfare, specifically, targets individuals and families in need, offering services, such as social services, food and income support, healthcare, education, and housing assistance. Social welfare policies and programmes are formulated as an essential part of a government's efforts to meet human needs and create a safety net for vulnerable groups.

Nonetheless, the responsibility to ensure social welfare does not rest entirely on the government. The idea of welfare pluralism and the mixed economy of welfare in Western welfare states have shifted the burden of welfare provisions to one of shared responsibility among the state, community or informal sector, voluntary or not-for-profit sector and the private sector.[1] Most countries now have, in practice, included a range of welfare provisions, with some services being provided directly by the state while the private market or voluntary organisations provide others.

Hence, people in need of help or care have four basic options for assistance. First, they could seek the support of their family, relatives, neighbours or friends (the community). Second, they may attempt to pay for services from private care providers. Third, they could look for free services from voluntary organisations or individuals. Fourth, they may turn to government social services. Therefore, when more than one option exists in care provisions, the ecosystem could be referred to as a "mixed economy of care".[2]

II. Sustainable Development Goals (SDGs) and gender parity

The care economy is also integral to several SDGs, including poverty reduction, promotion of health and wellbeing and education improvements. It supports gender equality and decent work, while seeking to reduce inequalities and foster inclusive communities.

Consider, for example, the fact that women are more dominant in care work. In Malaysia, both paid and unpaid care work are intertwined with the issue of gender parity. Traditionally, much of caregiving – such as looking after children, the elderly or people with disabilities – falls under unpaid care work. This work occurs primarily within households and is disproportionately performed by women. On the other hand, paid care work includes formal employment in sectors like healthcare, education and social services, and is often dominated also by women.[3] Nurses, teachers and social workers are part of this category.

Investing in the care economy, thus, could help Malaysia achieve gender parity, build a more equitable, sustainable future and improve the sector's workforce overall.

III. Growth of private service providers

As highlighted earlier, modern social welfare has shifted from the state's sole responsibility on welfare to a mixed economy of welfare with shared responsibility. Using health and education as examples, we can see the rapid growth of private service providers in these two sectors.

For example, the number of private clinics is almost triple that of public clinics.[4] Likewise, with the exception of primary and secondary schools, there are more private colleges and universities than public institutions of higher learning. Furthermore, the number of enrolments in private preschools from 2013 to 2020 also indicated an upward trend compared with enrolments in public preschools, which remained static.[5]

IV. Past policies on social welfare

Although the Department of Social Welfare (Jabatan Kebajikan Masyarakat – JKM) was established in 1946 and has been entrusted with providing various social welfare services, it was not until 1990 that Malaysia introduced its first specific policy on social welfare. The National Social Welfare Policy (NSWP) was launched in response to growing concerns about social problems affecting the country.[6]

In fact, NSWP lists several social ills seen as a threat to the nation's social wellbeing. These include increasing crime rate, prostitution, child abuse, school dropouts, juvenile delinquency, domestic violence, divorce, abortion, child abduction, elderly abuse, drug abuse and youth loitering.

It emphasised the need for collective efforts from individuals, communities, voluntary organisations, government agencies and private organisations to address these issues. The policy aimed to foster a sense of shared responsibility and encourage greater participation from all sectors.[7]

Taking this into context, it is clear then that the government was already looking into the concept of a mixed economy of welfare of encouraging more involvement from the community, non-governmental and voluntary organisations, as well as the private sector in the social welfare sector. However, it did not come up with any plan of action or measures to intensify the participation of the voluntary and private sector in welfare or care services.

From the social policy perspective, with the introduction of NSWP, social welfare in Malaysia was seen to have moved from a more traditional, reactive approach to developmental and preventive areas. It also sought to cater to the need to develop a more professional care service with minimum standards, as demonstrated by the enactment of the Care Centre Act 1993.[8] Despite this progress, NSWP is no longer prominently featured on official government websites and its current status remains unclear.

In 2003, the government officially launched the National Social Policy (NSP).[9] NSP is deemed "the umbrella policy that covers the philosophy and various national social development policies", which aims to "create a developed and well-established Malaysian community with each member having the opportunity to develop their potential to the optimum in a healthy social environment based on the characteristics of cohesive, resilient, democratic, moral, tolerant, progressive, caring, fairness and equity in accordance with the goals of Vision 2020."[10]

Here again, the idea of the mixed economy of welfare is embedded as it calls for a synergistic multisectoral collaboration between the public, private and voluntary sectors where social development is a shared responsibility.[11] Nonetheless, the lack of any plan of action, like NSWP, prevented the establishment of a clear policy direction to develop robust and sustainable social care provisions for the increasing care needs.

It is, therefore, heartening to note that the Ministry of Women, Family and Community Development (MWFCD) has drafted Malaysia's Plan of Action for Care Industry.[12] According to Minister Nancy Shukri, the document aims to produce skilled caregivers or care workers for children, older persons and people with disabilities. It also seeks to make care work a professional career.

The focus on building a skilled workforce for the care industry is an encouraging step forward. However, challenges remain in transitioning from a low-skilled to a high-skilled workforce and addressing the funding, promotion and involvement of non-profit organisations as well as the private sector in care provision. These factors will be crucial in shaping a robust and sustainable care economy for Malaysia.

8.3 Workforce and occupational standards in care industry

This section investigates the type of workforce and qualifications of occupational standards required in the care industry by examining several existing official documents in lieu of a lack of policy direction today.

From a broader perspective, the Global Social Service Workforce Alliance coined the term "social service workforce" and defined it as follows:

"...an inclusive concept referring to a broad range of governmental and non-governmental professionals and paraprofessionals who work with children, youth, adults, older persons, families and communities to ensure healthy development and wellbeing... The social service workforce constitutes a broad array of practitioners, researchers, managers and educators, including but not limited to, social workers, social educators, social pedagogues, child care workers, youth workers, child and youth care workers, community development workers/community liaison officers, community workers, welfare officers, social/cultural animators and case managers."[13]

This definition highlights several key points when examining the workforce in the care industry. First, care workers are part of the broader social-service sector, making care services an integral component of social services. Second, both government and NGOs can provide social services and care services. Third, the social-service workforce comprises of professionals and paraprofessionals or semi-skilled workers. In summary, there is a wide spectrum of skillsets and competencies within the care industry workforce.

However, in the absence of official documents that define social care in Malaysia, the social care workforce will be analysed based on several official documents, such as Malaysia Standard Industrial Classification (MSIC), National

Occupational Skills Standard (NOSS), Malaysian Qualification Framework 2nd edition (MQF 2.0), Malaysian Standard Classification of Occupations (MASCO) and National Education Code (NEC). This will help to provide a clearer picture of how social care is being perceived and classified as an industry in the country.

I. Malaysian Standard Industrial Classification (MSIC)

The MSIC code is a numerical system where each code corresponds to a specific industry, allowing for streamlined data collection and analysis. It is a standardised classification developed by the Department of Statistics Malaysia that aims to simplify the complex landscape of industries and classify economic activities into different sectors as well as sub-sectors.

The MSIC 2008 version 1.0 is an update of industry classification developed based on International Standard of Industrial Classification of All Economic Activities (ISIC) Revision 4. In this framework, social care sector falls under three divisions in section Q (human health and social work activities): division 86 for human health activities, division 87 for residential care activities and division 88 for social-work activities without accommodation (Table 8.3.1).

Table 8.3.1. Section Q (human health and social-work activities)

Division	Group	Description
Q86: Human health activities	Q861	Hospital
	Q862	Medical and dental practice
	Q869	Other human health activities
Q87: Residential care activities	Q871	Residential nursing care facilities
	Q872	Residential care activities for mental retardation, mental health and substance abuse
	Q873	Residential care activities for the elderly and disabled
	Q879	Other residential care activities

Q88: Social work activities without accommodation	Q881	Social work activities without accommodation for the elderly and disabled
	Q889	Other social work activities without accommodation n.e.c

Source: MSIC.

Under this classification, social care is more closely associated with Q87 and Q88, as Q86 is mainly related to health professionals regulated under the Health Ministry (MOH). The main difference in the division of social care is between residential care and non-residential care.

Table 8.3.1 shows that Q87 covers care for the elderly, the disabled, mentally retarded individuals, as well as people with mental health problems and/or substance abuse. Q879 expands this by covering children and other residential care activities in orphanages, welfare homes and others. Care for non-residents can manifest in the form of day care, for example, under group Q881. The bottom line is that both residential care or non-residential care services can be provided by government agencies or private organisations.

At this juncture, it would be good to clarify the meaning of social work in the MSIC classification and compare it to the definition of social work from the professional perspective.[14] While the MSIC classification does not define social work, its categorisation of activities into residential and non-residential care has inadvertently equated social work with care work.

Conversely, social work is globally recognised as a profession dedicated to helping individuals, families and communities enhance their wellbeing. It involves providing support, resources and advocacy to those in need, effecting positive change in people's lives and society. This disparity will be explored further in the qualification section of social care and social work.

It is also worth noting that earlier definitions of the social-service and social-care workforce distinguish care workers and social workers as two separate occupational groups, even though both are essential parts of the social-care and social-service workforce. In Malaysia, however, that differentiation appears vague.

II. National Occupational Skills Standard (NOSS)

NOSS is a standard established under part IV of the National Skills Development Act 2006 (Act 652) under the Ministry of Human Resources. NOSS is defined as a specification of the competencies expected of a skilled worker in Malaysia for an occupational area, level and the pathway to achieve competencies.[15]

Act 652 provides for the implementation of a Malaysian Skills Certification System, leading to the award of five levels of national skills qualification – Malaysian Skills Certificate level 1, 2 and 3; Malaysian Skills Diploma, and; Malaysian Skills Advanced Diploma.

The distinction between residential and non-residential care activities is used in developing the NOSS for classifying skills standards (Table 8.3.2). The skills standards for social-care workers, social welfare workers, community workers and social workers range from level 3 – which corresponds to a certificate level – up to level 5, which is equivalent to an advanced diploma.

Table 8.3.2. NOSS classification for social care, social welfare and social work

Type of service	Target group	NOSS	Level	MSCI code
Residential care	Pusat jagaan orang kurang upaya (disabled care centre)	Persons with disabilities (PWD) care centre operation	3	Q873
		PWD care centre administration	4	Q873
		PWD care centre management	5	Q873
	Pusat jagaan orang tua (elderly care centre)	Elderly care centre operation	3	Q873
		Elderly care centre administration	4	Q873
		Elderly care centre management	5	Q873
	Children care centre	Children care and progress	3	Q879
		Children care and progress supervision	4	Q879
		Children care and progress management	5	Q879

Non-residential/ day care	Children with special needs	Children with special needs care & education practice	3	Q889
		Children with special needs care & education administration	4	Q889
	Autism-education practice	Children with autism centre operation	3	Q881
	Community-based rehabilitation (PWD)	Community-based rehabilitation operation	3	Q881
		Community-based rehabilitation centre administration (PWD)	4	Q881
		Community-based rehabilitation centre management (PWD)	5	Q881
Other social-work activities without accommodation	Social welfare	Social welfare practice	3	Q889
		Social welfare coordination	4	Q889
		Social welfare management	5	Q889
	Community services	Community service	3	Q889
		Community service administration	4	Q889
		Community service management	5	Q889
	Social work	Social-work operation and administration	4	Q889
		Social-work management	5	Q889
Undifferentiated goods and service-producing activities of private households for own use	Early childhood care and development (ECCD)	Early childhood care and development education	3	T982
		Early childhood care and development supervision	4	T982
		Early childhood care and development management	5	T982

Source: Daftar Standard (Standard Registry), August 2024.[16]

As shown in Table 8.3.2, the NOSS developed for social care primarily focuses on three major care-dependent groups – children, the elderly and persons with disabilities (PWDs). Meanwhile, the NOSS for social welfare, community services and social work were created separately as non-residential services, emphasising on case work and social administration practices. Notably, NOSS for Q872 Residential Care Activities (mental retardation, mental health and substance abuse) has yet to be developed.

The earliest qualification for owners, operators, supervisors and childcare workers in early childhood care and development (ECCD) is Kursus Asuhan dan Didikan Awal Kanak-Kanak PERMATA (Basic Child Care Course – KAP), as mentioned in the Child Care Centre Regulations 2012 under the Child Care Centre Act 1984. KAP later served as a reference in developing NOSS level 3 for the ECCD.[17] Interestingly, ECCD is classified under section T, division T98, which indicates that ECCD can be provided as a home-based service while other social care services are seen as centre-based (residential or non-residential).

Therefore, among the three care-dependent groups, children receive the most attention in terms of NOSS while elderly care and people with disabilities are limited to residential care.

III. Malaysian Qualification Framework (MQF 2.0)

The Malaysian Qualifications Framework (MQF) is Malaysia's declaration on its education system's qualifications and quality. Its latest iteration, MQF 2.0, was developed by the Malaysian Qualification Agency.[18] The Higher Education Ministry has aligned NOSS under the technical vocational education and training (TVET) category with MQF 2.0 (Table 8.3.3).

Table 8.3.3. Malaysian Qualification Framework 2.0

MQF level	Academic level	TVET sector
8	PhD or doctoral degree	
7	Master's degree Postgraduate diploma Postgraduate certificate	
6	Bachelor's degree	
	Graduate diploma Graduate certificate	6

5	Advanced diploma	5
4	Diploma	4
3	Certificate	3
2	Certificate	2
1	Certificate	1

Source: Malaysia Qualification Agency (2024)

Under the MQF 2.0, the highest level attainable under the NOSS is 6, equivalent to a graduate diploma and one rank below an undergraduate degree. This classification shows that all social-care qualifications developed under NOSS are skills-based training, yet their skill level is considered lower than that of university graduates.

For example, in the public service's social (S) scheme, entry level qualifications for social development officers (S41) require an undergraduate degree recognised by the Public Service Department. For assistant social development officers (S29), a college diploma is required, while welfare assistants (S19) need a secondary school certificate (Sijil Pelajaran Malaysia – SPM).

In short, the qualifications and skillset of the social-care workforce range from semi-skilled (level 3) to skilled (level 5). This suggests that their salary scale might also be lower than that for graduates. Their recognition as professionals or paraprofessionals depends on the enactment of professional legislation, which is currently non-existing.

IV. Malaysian Standard Classification of Occupations (Masco)

The last instrument to be examined is Masco, which is the national benchmark for job classification within the labour force.[19]

Table 8.3.4 summarises the category of workers according to the Masco code, job title, the National Education Code (NEC) and level of skills required (NOSS). NEC serves as a platform to provide a coding system that will enable accurate tracking, assessment and reporting of the education and training programmes as well as registrations (at the tertiary level) in Malaysia.[20]

Table 8.3.4. Category of workers with Masco code, job title, NEC and NOSS level

Masco code	Job title	NEC	NOSS level examples
1614 Social welfare managers	**1614-01** Social work manager **1614-02** Social work operation manager **1614-03** Community centre manager **1614-04** Welfare centre manager **1614-05** Family services manager **1614-06** Housing services manager	**0921** Care of elderly and of disabled adults **0922** Child care and youth services **0923** Social work and counselling **0414** Management and administration	Social welfare management (level 5)
2825 Social work and counselling professionals (job title of 'counsellors' not included here)	**2825-01** Community development officer grade s41 **2825-02** Social worker, professional* **2825-09** Parole officer **2825-10** Probation officer **2825-11** Women's welfare organiser **2825-12** Youth and sports officer grade s41 **2825-13** Anti-drug officer grade s41	**0923** Social work and counselling	Social welfare coordination (level 4) Social work operation and administration (level 4) Social work management (level 5) Community service management (level 5)
1611 Childcare service managers	**1611-01** Childcare centre manager	**0922** Childcare and youth services **0923** Social work and counselling **0414** Management and administration	Children care and progress management (level 5) Early childhood care and development management (level 5)
1613 Aged care services managers	**1613-01** Aged care services manager **1613-02** Aged care home director **1613-03** Community aged care coordinator **1613-04** Aged care facility manager **1613-05** Nursing home care manager **1613-06** Aged care centre manager **1613-07** Aged care hostel manager **1613-08** Matron, nursing home	**0921** Care of elderly and of disabled adults **0923** Social work and counselling **0414** Management and administration	Elderly care centre management (level 5)

3611 Social work associate professionals	**3611-01** Social worker **3611-02** Social worker, group work **3611-03** Welfare officer, industry **3611-04** Welfare officer, probation **3611-05** Parole officer, associate professional **3611-06** Probation officer, associate professional **3611-07** Officer, family planning **3611-08** Social welfare worker **3611-09** Social welfare worker, case work **3611-10** Social worker, child welfare **3611-11** Social worker, delinquency **3611-12** Social worker, community **3611-13** Social worker, medical **3611-14** Social worker, psychiatric **3611-15** Welfare organiser **3611-17** Community development worker **3611-18** Community service worker **3611-19** Disability services officer **3611-20** Family service worker **3611-21** Life skills instructor **3611-22** Mental health worker **3611-23** Welfare support worker **3611-24** Women's shelter supervisor **3611-25** Youth worker **3611-26** Assistant social research officer grade n29 **3611-27** Assistant community development officer grade s29 **3611-28** Assistant psychological officer grade s29 **3611-29** Assistant anti-drug officer grade s29 **3611-30** Assistant executive officer (psychology) grade 31	**0921** Care of elderly and of disabled adults **0922** Childcare and youth services **0923** Social work and counselling	Social work management (level 5) Social work operation and administration (level 4) Social welfare coordination (level 4) Social welfare practice (level 3) Community based rehabilitation centre administration (PWD – level 4) Community-based rehabilitation operation (level 3)

5311 Childcare workers	**5311-01** Childcare worker **5311-02** Baby amah **5311-03** Nanny **5311-04** Babysitter	**0922** Childcare and youth services **0923** Social work and counselling	Carer (after school) (level 2)
5322 Home-based personal care workers	**5322-01** Care aide (home) **5322-02** Birth assistant (home) **5322-03** Nursing aide (home) **5322-04** Personal care provider **5322-05** Care aide (home) grade K3 **5322-06** Assistant, day care: aged **5322-07** Companion, aged care **5322-08** Helper, aged care **5322-09** Helper, caring for aged (home) **5322-10** Worker, home care **5322-11** Assistant, day care: disabled **5322-12** Helper, caring for infirm (home)	**0921** Care of elderly and of disabled adults **0922** Childcare and youth services **0923** Social work and counselling	Healthcare support service (level 2)

Source: Adapted from Masco, NEC and NOSS

In the social welfare and social care sector, Masco categorises the workforce into four levels. At 1,000, the highest level, we find managerial positions occupied by individuals with tertiary degrees, such as social welfare managers, childcare service managers and aged care managers. Level 2,000 consists of officers with undergraduate degrees. Level 3,000 includes associate professionals, such as diploma-level officers. Finally, level 5,000 encompasses care aides, assistants and helpers, who may or may not have completed SPM but are required to achieve at least level 2 in NOSS.

Based on Table 8.3.5, the social care workforce in Malaysia appears well structured on paper, with clear job titles, qualifications, standards and projected career paths. In reality, only social work and counselling programmes are readily available at the tertiary level. The Counsellors Act 1998 mandates a bachelor's degree as the minimum qualification for registered counsellors. Although social work lacks professional legislation, its education programmes are well established, ranging from diploma to PhD.[21] Conversely, for social care, only ECCD is available at the tertiary level, while education programmes for the elderly and PWD care are primarily at the NOSS level.

Therefore, it can be summarised that occupational standards and qualifications for care workers remain at a lower level or vocational training, whereas managers of care centres or services are regarded as high-level professionals. Social workers' occupational standards range from middle to high, depending on their entry qualification.

Table 8.3.5. Mapping of area of care, type of service providers, relevant legislations and authorities, and main workforce for care-dependent people

Target group	Area of care/ services	Examples of services	Main service providers				Main legislation/ regulation and authorities	Main workforce	Qualifications
			G	N	P	C			
Children	General day care	Childcare centre (Taska)	/	/	/	/	Child Care Centre Act 1984 – JKM	Childcare worker/ caregiver (pengasuh)	KAP
		Preschool	/	/	/	/	ECCE Policy – MOE	Early childhood educator	ECCD
	Residential care	Children home	/	/			Child Act 2001 Care Centre Act 1993 – JKM	Care worker Social/case worker Welfare worker Nursing aide	Not specified
	Child protection care	Children home	/	/			Child Act 2001 Care Centre Act 1993 – JKM	Care worker Social/case worker	Not specified
Older persons	Day care	Elderly day care centre		/	/		National Older Persons Policy 2011 Care Centre Act 1993 – JKM Private Aged Healthcare Facilities and Service Act 2018 – MOH	Care worker Nurses and allied health professionals	Not specified Nurses Act 1950 Allied Health Professions Act 2016
	Residential care	Rumah seri kenangan Rumah ehsan Old folks' home	/	/	/	/	National Older Persons Policy 2011 Care Centre Act 1993 – JKM Private Aged Healthcare Facilities and Service Act 2018 – MOH	Care worker Social/case worker Welfare worker Nurses and allied health professionals	Not specified Nurses Act 1950 Allied Health Professions Act 2016

Older persons (cont.)	Elderly activity centre	Pusat aktiviti warga emas (PAWE)	/	/			National Older Persons Policy 2011 Garis Panduan Pusat Aktiviti Warga Emas (PAWE) Pindaan 2018 – JKM	Centre supervisor (penyelia) Social/case worker Welfare worker	Not specified
	Nursing care (private)	Nursing home			/		Private Aged Healthcare Facilities and Service Act 2018 – MOH	Nurses and allied health professionals	Nurses Act 1950 Allied Health Professions Act 2016
People with disabilities	Community-based rehabilitation/ Day care	Pertubuhan pemulihan dalam komuniti (PPDK)		/	/	/	Persons with Disabilities Act 2008 – JKM	PPDK teachers Centre supervisor	Not specified
	Residential care	Taman sinar harapan Care home for PWDs	/	/			Persons with Disabilities Act 2008 Care Centre Act 1993 – JKM	Care workers Social/case worker Welfare worker	Not specified
	Pwds activity centre	Sheltered workshop (bengkel daya)	/	/			Persons with Disabilities Act 2008 – JKM	Centre supervisors Social/case worker	Not specified
	Mental health related services (non-residential care)	Mental health treatment and therapy	/				Mental Health Act 2001 – KKM	Health and mental health professionals Social/case worker Welfare worker	Medical Act 1971 Nurses Act 1950 Allied Health Professions Act 2016
				/	/		Persons with Disabilities Act 2008 – JKM		Not specified

Note: G: Government, N: NGO/Non-profit, P: Private, C: Community, JKM: Department of Social Welfare, MOH: Health Ministry, MOE: Education Ministry

8.4 Service providers in care industry

After a deliberation on the social care workforce, we will now move on to the service providers in the care industry. As discussed earlier, care service can be provided by government, non-government, private sector and the community. Table 8.3.5 is developed to give a simple and non-exhaustive mapping of area of care, type of service providers, legislations, relevant authorities and main workforce for three target groups. The care for people with long-term mental health problems will be discussed together with PWDs as chronic mental illness is categorised as one form of disabilities under the Persons with Disabilities Act 2008.

From Table 8.3.5, it is quite clear the main government agencies involved in social care services are JKM under MWFCD and MOH. Among these services, children day care (taman asuhan kanak-kanak – Taska) was the first one to be regulated through the Child Care Centre Act 1984, demonstrating a mixed economy of care approach with services provided by the government, private sector, voluntary groups and community. This sector is sometimes lumped together as early childcare and education (ECCE).[22]

Nonetheless, the scope of work and workforce in this sector are regulated by the Education Ministry (MOE) as compared with those working in child residential as well as those working for older persons and PWDs.[23] There is also more private-sector participation in child day care compared with other care services.

The next care service that exhibits a mixed economy of care is care for older persons. In the absence of a specific legislation on older persons, the main references on elderly care falls upon the National Policy on Older Persons 2011, Plan of Action on Older Persons, Care Centre Act 1993, Private Aged Healthcare Facilities and Service Act 2018.

In this regard, JKM regulates elderly general care services in the public and voluntary sector, while MOH regulates elderly nursing care services run by the private sector. As MOH already has legislations that regulate the health and allied health professions, the workforce in private aged healthcare is more clearly defined and regulated compared with care centres regulated under JKM.

On the other hand, care service for PWDs is still dependent on the government and non-government/non-profit sector, with very little participation from the private sector.[24] The community-based rehabilitation (pemulihan dalam komuniti – PDK) model was initiated by JKM in 1984 as an early detection and intervention service for PWDs. By 2018, all PDK have been registered with the Registrar of Societies as a non-government organisation. PDK now receive grants from JKM for the purpose of providing allowances to trainees with disabilities, utility expenses, rental, supervisor and staff allowances, as well as contributions to Employees Provident Fund, Social Security Organisation (Socso) and activity grants.[25]

Finally, the social service for people with mental health problems are limited. Most mental health services are provided by MOH, NGOs and smaller number of private providers.[26] These are still underdeveloped and insufficient to reach those living in the rural areas.[27] Nevertheless, the workforce is predominantly trained health and mental health professionals.

In summary, when considering the care economy in Malaysia, social care services exhibit varying degrees of development and regulation. The workforce also varies depending on types, sizes and scope of services provided by each organisation. Social workers, nurses and allied health professionals may be employed by more established agencies or organisations.

Notably, services for children are comparatively better established, benefiting from a diverse mix of providers. Following closely are services for older adults. Consumers in these categories are increasingly willing to pay for these services, leading to greater private-sector participation.

However, the landscape changes when we turn to PWDs. While care services for children with disabilities receive significant government support through organisations like community-based rehabilitation centre (pertubuhan pemulihan dalam komuniti – PPDKs), the same level of availability is lacking for adult PWDs. Persistent barriers related to participation and inclusion continue to challenge the accessibility and affordability of care for PWDs.[28]

To foster the growth of the care economy, it is essential to establish a robust market for the care industry. This market should not only encourage greater participation from diverse providers but also entice individuals to view the social care sector as a viable career path.

8.5 Gaps in care industry

Discussions surrounding the care economy and industry in Malaysia are relatively recent. Referring to Table 8.3.5 as a guide, where does Malaysia stand in terms of its care industry? Can we confidently label it an "industry" in which the production of goods and services are quantified? Is it appropriate to call it "care industry" when services are primarily provided by public agencies and voluntary organisations? Furthermore, can we use the term "care industry" when the workforce remains unregulated and is often perceived as having low skills and low wages?

We need to consider gaps from the market, workforce and consumers' perspectives.

I. Gaps from market perspective

The earlier discussion points out that only childcare and elderly care, to a certain extent, exhibit indicators of a mixed economy of care where there is also participation from the private sector as service providers. It has been projected that the private sector is more interested to enter the care industry as demand for childcare and elderly care is rising, with market potential for the care economy reaching US$25.5 billion (RM114.2 billion).[29]

Nonetheless, the social care sector in Malaysia is still underdeveloped and relies heavily on government services and charity. One of the primary issues is the lack of financial investment and infrastructure to support a sustainable market. Government funding and charitable donations often fluctuate, making it difficult to establish a stable financial base for care services to enhance quality and expand capacity. This instability can discourage private investors and businesses from entering the market, as the potential for consistent revenue is uncertain.

In addition, profit margins in the care industry can be relatively low compared to other sectors. The high cost of setting up care facilities and providing quality services, coupled with the expectation of low revenue, could deter private investment. The care sector is also subject to stringent or inconsistent regulations, which can be costly and complex for private companies to navigate.[30] Compliance with these regulations requires significant resources and can be a barrier to entry.

Moreover, the reliance on government services and charity creates a cultural expectation that care should be free or heavily subsidised. Introducing a market-based system could face resistance from both the public and policymakers accustomed to these services being provided as a public good. This expectation can make it challenging to implement fee structures or insurance models that are typical for a market economy, as they may be seen to be unfair or inaccessible to those in need.

Lastly, the fragmented nature of an underdeveloped care economy could lead to inefficiencies and duplication of services. The care industry can be highly fragmented because of the presence of many small providers and a lack of coordination between services. This fragmentation can make it difficult for private companies to establish a significant market presence and achieve economies of scale.

II. Gaps from workforce perspective

The underdevelopment of the care economy means that there is a lack of investment in human capital development, often resulting in a shortage of trained and skilled workers. When services are predominantly provided by public agencies and voluntary organisations, there is limited incentive for professional development and career advancement within the sector.

This could result in a "low-skilled" and poorly paid workforce, further hindering the attractiveness of the care industry as a viable market. Without proper regulation and standardisation, the quality of care provided can vary widely, impacting on the trust and reliability necessary for a successful market-driven economy.

Low-skill requirements and low pay in the social care sector could deter young people from entering the workforce. The perception that care work is undervalued and underpaid discourages local youth from pursuing careers in this field, as they seek job opportunities that offer better financial stability and career growth.

Additionally, the lack of advanced training and professional development options within the sector makes it difficult to attract young professionals looking to build a meaningful career. This leads to a vicious cycle where the care sector struggles to attract young people, further perpetuating the issues of low skill and inadequate wages. In the end, we may still have to rely on foreign workers.

III. Gaps from consumer perspective

In the business sector, consumers are presumed to have purchasing power to obtain the products or services they want. They can choose from many providers and pick the best service. However, this dynamic does not translate easily into social services as consumers seeking assistance from human services might not have the purchasing power of an ordinary population.

For instance, Caplovitz argued that consumer protection legislation "is based on a model of the 'sophisticated' consumer, not that of the 'traditional' consumer prevalent among low-income families."[31] Most people seeking and receiving assistance in social services are from low-income families. They often lack resources (such as education, money, housing and jobs), limiting their ability to exercise their rights. Caplovitz contended that consumer-protection legislation alone cannot guarantee consumer rights, as low-income consumers often fail to understand or exercise their legal rights.[32] Furthermore, these consumers are often poorly equipped to recognise when their rights have been violated.

In social care, vulnerable groups, such as children, elderly persons and PWDs, face significant challenges exercising their rights as users of social services. These individuals often experience barriers related to communication, mobility and comprehension, which could hinder their ability to advocate for themselves and access necessary support. Children lack the cognitive and emotional maturity to understand their rights and voice their needs effectively. The elderly might struggle with physical frailty, cognitive decline or social isolation, making it difficult for them to navigate complex systems and demand their entitlements.

People with disabilities might face additional hurdles because of inadequate accommodations, social stigma and discriminatory practices. The question is, does Malaysia's social care workforce have the competency to empower their clients to understand and voice out their needs, especially if their occupation standards are low?

To address these issues, it is crucial to develop targeted strategies to enhance consumer rights within the social care sector. This could include increased education as well as awareness programmes to help individuals understand and exercise their rights. Besides, stronger advocacy and support networks are needed to assist those who might be vulnerable. Implementing clear and enforceable regulations that protect the rights of consumers and ensure that care providers uphold these standards can also bridge the gap. By fostering a more inclusive and equitable system, we can work towards ensuring that all individuals, regardless of their socioeconomic status, have access to the rights and protections they deserve.

8.6 Ways forward for workforce

This section offers several steps to raise the standards of the workforce and viability of the care industry overall.

I. Regulating training and occupational standards of social care workforce

NOSS has set the occupational standards for childcare, elderly care and care for PWDs. However, a regulatory framework mandating these standards and related qualifications for the social-care workforce is lacking.

MWFCD should emulate the measures taken by MOH and MOE by getting JKM to specify relevant qualifications under the Child Centre Act 1984 and Care Centre Act 1993. Initially, service providers should be encouraged and incentivised to employ individuals with social care qualifications. Besides, service providers must not be penalised if their current workforce lacks these qualifications, provided that their workers attend the stipulated training within a time frame.

To enhance the regulatory framework, a comprehensive monitoring and evaluation system should be established. This system would ensure that service providers adhere to the prescribed standards and that the training programmes are equipping care workers with the necessary skills. Regular assessments and audits could be conducted to verify compliance as well as identify areas for im-

provement. Additionally, a continuous professional development programme should be introduced to help care workers keep updated with the latest best practices and advancements in the field.

Another essential step would be to raise public awareness about the importance of professional qualifications. Public campaigns and informational sessions could highlight the benefits of employing qualified care workers, not only for the quality of care provided but also for the overall wellbeing of the service users. By creating a culture that values and recognises professional qualifications, the sector can attract more skilled individuals and enhance its reputation as a vital component of social services.

8.7 Professionalising workforce

Within the social care workforce, social work is a more developed profession in terms of education and training, and recognised as a field of study at the tertiary level. As the standards set for care workers are primarily at the vocational level, it is recommended that the government pass the Social Work Profession Bill to start professionalising the entire social care workforce. Through legislation, the government can regulate qualifications and set standards for social workers to safeguard the interests as well as wellbeing of those needing social services, while the rest of the care workforce is regulated through certification of occupational standards.

Additionally, establishing a national licensing system for social workers can ensure uniform standards and accountability. This system could include mandatory education and professional development requirements, fostering a culture of lifelong learning and skill enhancement among social workers. By promoting career pathways and advancement opportunities within the social work profession, the care industry can attract and retain more skilled individuals, ultimately improving the quality of services provided. A similar approach can be used by the government to professionalise the rest of the care workforce when the timing is right. Most of all, it must be cognisant of the importance of having a professional social-care workforce and not leave care work to a low-skilled workforce or charity organisations.

I. Making care work and care industry viable

To ensure the viability of its care industry, the government must establish a clear policy direction for the care economy and create a comprehensive blueprint. A practical starting point for the government and relevant stakeholders is to focus on childcare and elderly care services as the foundation for the care industry.

Childcare services are more advanced, with established education and training pathways as well as regulated standards. The demand for ECCE at the tertiary level is attractive, as the private sector is willing to offer higher salaries to graduates with a diploma in ECCE compared with those with a level 3 NOSS in childcare. However, the issues of unregistered childcare facilities and services require more intense intervention from the authorities to ensure the safety and wellbeing of cared-for children.

Elderly care services are also increasingly in demand as Malaysia moves towards an ageing society and undergoes demographic changes. The quality of care varies significantly between non-profit or charity-based facilities – which often rely on untrained staff – and private nursing care or nursing homes that can afford to employ qualified health professionals. Many elderly individuals prefer to age in place, remaining in their homes and communities. The care industry must address the high costs associated with domestic caregiving and need for specialised care services.

To make the care industry attractive to young Malaysians and also reduce reliance on foreign workers, it is crucial to develop a robust sector that offers higher income and clear career pathways for care workers. Engaging with young people involves promoting awareness of the diverse roles within the sector, emphasising on its societal impact and showcasing success stories of care professionals. Highlighting clear educational pathways and career progression opportunities is essential. Young people need to see how their skills and interests align with meaningful roles in caregiving, whether as nurses, social workers or allied health professionals.

Additionally, the government should introduce incentives, such as scholarships, grants and loan forgiveness for students pursuing careers in the care sector. Strengthening partnerships between educational institutions and care providers can facilitate internships and job placements, further encouraging young people to enter the field. By investing in professional development and providing competitive salaries, the care industry can attract and retain a skilled workforce.

8.8 Conclusion

A viable and sustainable care industry in Malaysia cannot develop organically. It requires clear policy direction, supportive legislation and a robust regulatory framework to establish a mixed economy of care that includes service providers, social care workforce and users. Comprehensive policies and a structured regulatory framework will ensure that the standards of care are maintained, the workforce is trained and the services meet the needs of the population.

Childcare demonstrates significant readiness in terms of market demand within the care industry, followed by elderly care. These two sectors could serve as catalysts for developing the broader care industry in Malaysia. Childcare services are already more advanced, with established education and training pathways as well as regulated standards. Elderly care services are increasingly in demand because of an ageing population and demographic shifts. By focusing on these areas, we can build a strong foundation for the care industry.

Moreover, regulating the social care workforce is essential to ensure competent service delivery and safeguard the wellbeing of care-dependent individuals. Implementing mandatory qualifications, continuous professional development and regular assessments will enhance the quality of care. It is also crucial to address the issues of unregistered facilities and services to ensure compliance with safety standards.

To make the care industry attractive to young Malaysians, it is important to offer competitive salaries, career progression opportunities and a positive working environment. Engaging with the younger generation through awareness campaigns about the societal impact of care work and showcasing success stories can help draw more people into the sector. By investing in the care workforce, we can create a robust, sustainable and respected care industry that meets the needs of all Malaysians.


NU-GEL

9

Care economy as growth sector

SDGs could help the nation pursue humane and justice-based development while serving the impoverished

Teo Lee Ken

9.1 Social transformation and need for care

Trying times require paradigm shifts in ideas and action. As society changes, national agendas perform a pivotal role in facilitating great transformations.[1] Malaysia is at such a juncture, with reports noting that by 2030, there will be around six million Malaysians aged 60 and above.[2]

Against the backdrop and consequences of the Covid-19 pandemic, the Malaysian government has noted that "prudent fiscal management is imperative to ensure fiscal sustainability in achieving the development agenda." Furthermore, such measures have socioeconomic impacts on Malaysian society, as there are limitations in its reach to ensure social services and delivery for the public.[3]

One such arena is that of the social and care sector. In view of this, the government has embarked on a project to build and consolidate Malaysia's care economy.[4] The target groups or beneficiaries of care services include people with disabilities (PWDs), people with special needs, children and children with special needs, and senior citizens.

Because of space constraints, this chapter does not cover those with mental health conditions as part of the care economy and care service target, despite their vulnerabilities. Chapter seven, written by Andrew M Chandrasekaran and Laura Kho Sui San, explores this area.[5]

The care economy's contributions to Malaysia can be viewed in two ways. The first is the role of the care economy itself as an engine of economic growth – this should be seen not only in material terms but also social terms.[6] The second is how, by creating and running a care economy, it allows segments of a society – particularly women and mothers, among others, who are confined to formal or informal care work – to participate in the labour market.

For the purposes of this chapter, it is this first point that our discussion seeks to evaluate critically.

In a recent publication by the Institute of Strategic & International Studies (ISIS) Malaysia, the authors of a study noted that unpaid care work could contribute around RM379 billion to Malaysia's gross domestic product (GDP). If true, the care economy would have been the fifth biggest contributor among the service sector.[7] The study further notes that if those who are kept outside employment or full-time work are unrestricted by household or familial responsibilities, an

additional 3.2 million workers will have the opportunity to enter the labour market as a productive workforce.[8]

Deputy Economy Minister Hanifah Hajar Taib estimated the market value of Malaysia's care economy at US$25.5 billion (RM114 billion).[9] The socioeconomic benefits the care economy might bring to the country, coupled with the present financial limitations of the government, have rendered as urgent the need to find alternatives to the existing care economy system.[10]

This chapter is divided into four parts. First, the introduction discusses the background and context for the emergence of the perspectives that see care services and sector as an economy. Second, it discusses some key highlights and benefits in building the care economy as an industry and growth sector in Malaysia. Third, it seeks to highlight some of the challenges following moves to develop the care economy as a growth sector. It examines some of the social and economic implications this move might have on Malaysian society. The chapter ends with some concluding thoughts and presents key areas as well as recommendations that the government, policymakers, researchers, academics, activists and community workers should attend to in discussing this subject matter.

The attempt to discuss the care economy as a growth sector focuses not only on the quantitative aspects and numbers, it will also assess the qualitative dimensions, including the benefits of establishing a care economy. Throughout the discussions in the chapter, there are references to the findings from issue mapping and work of the All-Party Parliamentary Group on Sustainable Development Goals (APPGM-SDG) as well as the Sustainable Development Goals (SDG) agenda.

9.2 Malaysian society and care economy

I. Context and gaps

Discussions about the care economy in Malaysia, though not as widespread among the public, are not new in policy circles and among care service providers or operators. These discussions commenced in 2023 in an earnest and systematic manner.

Policy papers and reports focusing on this area include:

Table 9.2.1. Policy papers and reports on Malaysia's care economy

Name of document/activity	Publisher/convenor
Time to care: gender inequality, unpaid care work and time use survey	Khazanah Research Institute (2019)
How can an inclusive and resilient care ecosystem be built? Care delivery models to advance women's economic empowerment	Asia-Pacific Care Economy Forum (2023)[11]
Care economy dialogue: towards a resilient and sustainable care economy in Malaysia	The Asia Foundation (2023)[12]
Investing in the care economy: opportunities for Malaysia	United Nations Development Programme (UNDP) (2023)[13]
Enabling investment into the Malaysian care economy	UNDP (2024)
Malaysian care economy: landscape analysis	UNDP (2024)
Building a cradle-to-grave care economy for Malaysia	ISIS Malaysia (2024)[14]
Roundtable discussions: conversations on the care economy in Malaysia	ISIS Malaysia and APPGM-SDG (2024)[15]

Source: Author's tabulation

Together, these papers present a cogent case for the establishment of a care economy and how it will contribute to the country's growth.[16] The UNDP 2024 report 'Enabling investment into the Malaysian care economy', for instance, argues that resources allocated for the support of a care economy should be seen as an investment that will result in positive gains consisting of GDP growth, job creation and generation or increase in income levels.[17]

Referring to the 'Malaysian care economy: landscape analysis', the report suggests that if the government were to invest in the care economy, it could lead to a 6% increase in GDP, 9% increase in employment and 11% increase in income.

While these reports demonstrate sufficiently the economic and monetary case for a care economy in Malaysia, the discussion that ties it back to the SDGs is absent or lacking in analysis. Except for two papers by UNDP, the remaining five documents do not provide in-depth discussions on the role of SDGs in the growth of the care economy, or relate them to the care industry.

In addition, the papers above do not focus on the everyday realities of vulnerable communities and specific groups nor do they prioritise the on-the-ground challenges encountered by such groups, service providers as well as operators in their daily running of care services and facilities.

These papers also do not allude to the constraints of governance structures and administration confronted by the government. The neatly divided jurisdictions of power among ministries and agencies pose a critical challenge. Another issue is the lack of public policy and administrative innovation, which encumber the capacity of the state and government machinery to initiate cross-sectoral processes required for the progress of a modern care economy. The last point of institutional and governmental immobility will not be discussed here.

The purpose of this chapter is two-fold and seeks to complement existing literature on the care economy as a vehicle of growth in two ways. First, it highlights SDGs and their framework, including the principle of "leaving no one behind". It argues for the centrality of SDGs in the building of a care economy and that growth ought to be seen as social growth as well as development. Second, the chapter highlights some of the views of communities dependent on care services and assistance. These narratives are derived from the localisation work of the APPGM-SDG incorporating, among others, issue mapping, grounded research as well as policy advocacy.

9.3 Structure, highlights and benefits

I. Care work and care economy in Malaysia: structure and scope

Both internal and external factors mark the care economy as necessary and distinctive in contrast to other economic industries and sectors.

As highlighted earlier, the estimated value of unpaid care in Malaysia is about RM379 billion. Internally, the absence of or unwillingness to recognise the presence of an existing field of care work in Malaysia has deprived caregivers, par-

ticularly women, of the financial remuneration and social support they deserve.[18] The failure to recognise the burden and value of caregiving also reinforces gender stereotypes and gender imbalance relations in society. The implication of this is that caregiving is "considered a natural responsibility of women and girls".[19]

The formal recognition and institutionalisation of a care economy ensures that an area of work that has so far been rendered invisible is given value. Such measures also confer rights and socioeconomic benefits, especially to those engaged in such work. The presence of a care economy also serves to minimise and correct gender-biased stereotypes and inequality that occur in families and society in Malaysia.

External factors have also pushed the care economy to the forefront, compared to other economic sectors and drivers. This is thanks to ongoing shifts and crises at the global level with repercussions for the domestic landscape. These include unemployment, inequality, technological disruptions, demographic changes, climate change and reduction in public spending.[20] A viable care economy, thus, is essential to address these transformations and challenges.

The care economy, in its basic scope, caters to three groups. These groups consist of the elderly, children and PWDs. Categories of care for the elderly include at-home care, home-based care, rehabilitation, government or private medical centres or hospitals, education and counselling, long-term care, special care, social activities and residential elderly facilities.

Care for children consists of early childhood (including birth and childcare), after-hour care, books and educational products. It also covers care for school-going children. Under the latter, care provisions include food and transportation, after-school programmes and special needs.

For PWDs, particularly adults, the scope of care involves physical or biological, developmental, sensory impairment and behavioural or emotional.[21]

II. Needs and benefits of care economy

Owing to the diverse nature of needs and services provided to different communities by numerous stakeholders, the consolidation of a care economy would create more employment opportunities, drive economic growth and contribute to Malaysia's GDP. It would also cushion the state's burden in the provisioning of care services, allowing the growth of private enterprises and operators, and providing better as well as professional care services that cater to the vulnerable and left-behind groups' needs.[22]

The attainment of those objectives and outcomes of these processes would be positive if the government could foster an effective ecosystem. Such an ecosystem must be capable of balancing the needs and addressing the challenges faced

on the supply side (e.g. service operators and care providers) and demand side (e.g., vulnerable communities, target groups and the poor).

The are several advantages in building a care economy. A care economy facilitates more public-private collaboration, allowing the private sector and care operators to be more involved in providing care services. Existing operators and stakeholders would welcome a growing care economy as it would allow them to run their operations and expand their services in different ways.

More employment opportunities could be created and the number of caregivers as well as care receivers among the vulnerable groups can be increased. Moreover, it would increase awareness and access to these services and programmes, as media coverage on the care economy would increase.[23]

To realise these benefits, various key stakeholders have come together through different NGO and industry networks. There is a recognition at the grassroots and practitioners' level that policies and services in the care sector need to be streamlined. This is to cater to the demands of social change and needs of society. At the national level, the government has led initiatives for these efforts.

Some operators, service providers and networks have been active in engaging the government to institutionalise a care economy. These include the Association for Residential Aged Care Operators of Malaysia, Komune Care, ECON Healthcare Group, ECON Medicare Centre and Nursing Home, Seterra Group, Kiddocare and Society for the Registered Early Nurturing and Development of Children Malaysia (Persatuan Pengasuhan dan Perkembangan Awal Kanak-Kanak Berdaftar Malaysia).[24]

Furthermore, the Ministry of Women, Family and Community Development (MWFCD) – in partnership with The Asia Foundation and PEMANDU Associates – organised a workshop in June 2024 to discuss the government's initiatives to develop a care economy roadmap and action plan. Operators and the private sector in attendance responded positively. Noting how many of the earlier initiatives and past programmes have focused heavily on the government as the main provider, a public-private collaboration would decentralise care services and minimise the federal government's financial and administrative burdens.

Following this, MWFCD and stakeholders involved viewed the establishment of a care economy as potentially increasing the standard of care services. As many of these sectors and services are run informally – and within community or residential settings – the level of expertise possessed by caregivers, formal or informal, also varies. By creating a care economy and professionalising services, caregivers and social workers will be better equipped with the skills to manage the needs as well as issues of the target groups.

Discussing standards of care services cannot be separated from the discussions on legal and regulations.[25] At present, there are various laws derived from different legislations that overlap each other. Legal provisions that govern children

affairs in the areas of care and education, for instance, come under the Education Ministry (MOE), MWFCD and Ministry of National Unity, among others.

Streamlining laws and regulations will contribute to the institutionalisation of a functioning care economy. These would include laws, rules and regulations that cover the needed qualifications and skills to run social and care services. Furthermore, it would also provide the foundation, both legal and policy, to establish a national-level council that governs the care ecosystem. The council would comprise of diverse stakeholders, including the government, the public sector, private operators, academics, policy researchers, activists and community as well as social workers.

To facilitate the establishment of benchmarks and standards for care centre premises and facilities, legal frameworks and regulations must also be introduced. As many social and care services remain informal and situated in residential settings, the formation of a care economy would fill in some of the gaps and weaknesses.

Finally, formalising a care economy would ensure the sustainability and inclusivity of the care sector and practices. The government does not have infinite resources and capacity to sustain long-term provisions of social services through public expenditure and subsidies. The government is also incapable of continuously providing grants generally and extensively.

There is a need, therefore, for care service providers and operators to shift from being recipients of grants and subsidies from the government to becoming social enterprises or organisations. Doing so would ensure that care services and facilities are sustainable in the long term, and are able to obtain the capacity to employ skilled and professional caregivers instead of relying only on volunteers. The benefit would especially compound for care centres and providers in rural areas.

Simultaneously, to guide this shift, the frameworks of the SDGs and the social and solidarity economy (SSE) are instructive. They provide guidelines to build a sustainable and inclusive care economy project that caters to the needs of the most vulnerable, including key target groups. The former, for instance, propagates the principle of leaving no one behind – amplifying the voices of communities excluded from mainstream economic development – and seeks to address the local needs of groups marginalised from public and social services through their 17 goals. These groups include families in the lowest income brackets, single mothers, PWDs and communities in the rural regions of Malaysia.[26]

Meanwhile, the latter advocates for entrepreneurship and economic models that function for the "collective and/or general interest" and based on the principles of "voluntary cooperation and mutual aid", "democratic and/or participatory governance" and more importantly, the "primacy of people and social purpose over capital in the distribution and use of surpluses." In the transition from the informal to the formal, an SSE framework allows for economic growth and the values of fairness and equality to go hand in hand.[27]

Overall, Malaysia's care economy could contribute to the growth of the country in material, economic and social terms by undertaking the above imperatives. These include institutionalising public-private collaborations, improving standards for care services and practices, creating uniform and coherent legal frameworks, and ensuring sustainability and inclusivity.

9.4 Challenges in consolidating care economy as growth sector

Notwithstanding the potentials and benefits of formalising a care economy and professionalising care services, critical challenges remain. Many of these issues are on the demand side, such as groups that reside in the rural peripheries and those mired in cycles of poverty.

I. Lack of access and affordability

In the research work undertaken by APPGM-SDG, for instance, findings illustrate that many of the social services related to care or within the area of care are subscribed by the B40 communities.[28] These communities have neither the financial resources nor capacity to access decent social and care services, such as those offered by the pertubuhan pemulihan dalam komuniti (community-based rehabilitation – PPDK) centres in rural and semi-urban areas.[29]

In Kuantan (Pahang), for instance, a PPDK centre lacks financial resources to run its activities in the long term. Meanwhile, in Gua Musang (Kelantan), these centres suffer from infrastructural problems, requiring substantial and urgent renovation. In Tasek Gelugor (Penang), a centre is struggling to disburse financial allowances to trainers and run programmes.

Some of the shared views are as presented below.

"Paling ketara adalah berkenaan dengan elaun-elaun dalam petugas. Sebab sekarang ni kita punya elaun tu adalah sagu hati bukan gaji."[30] (The most obvious is allowances for staff. This is because an allowance is identified as a token of appreciation and not a salary.)

Meanwhile, many caregivers and trainers do not receive the minimum wage.

"Untuk dapat gaji yang minimum tu, memang tak boleh lah sebab kita kan sagu hati, kita ikut apa yang diberi oleh kerajaan… Kalau macam sekarang, elaun untuk penyelia adalah RM1,500, untuk petugas RM1,200."[31] (To obtain the minimum wage is difficult because we receive a gift of appreciation, in accordance

with what is given by the government. For now, the allowance for a supervisor is RM1,500, and for the staff it is RM1,200.)

There is also the concern on the part of the centre that if the allocation of funding and resources is discontinued because of privatisation, there would be significant impacts on the participants' families as many are from B40 families. Without constant funding, the centres would not be able to function.

"Kami risau juga kalau jadi pusat jagaan nanti mungkin... akan lepaskan kita untuk bergerak sendiri."[32] (All of us are concerned that if we are turned into care centres... and we will be left to operate on our own.)

"Nak bergerak macam mana? Kalau daripada segi elaun kalau dia nak suruh kita cari, memang kami tak akan mampu. Kalau kita nak bayar sewa pun tak akan mampu."[33] (How are we supposed to operate? In terms of the allowance, if they want us to look for it, for sure we would not be able to do so. We would not even be able to pay the rent.)

For instance, even the present funding could only cover operational costs.

"Sebenarnya kita dapat geran perbelanjaan daripada kerajaan ya. Tetapi untuk sagu hati kepada petugas, elaun pelatih, utility sahaja... cumanya daripada segi untuk kita nak run aktiviti, kita perlu cari dana sendiri"[34] (We only receive an expenditure grant from the government. But this is only enough for the tokens of appreciation for the staff, trainee allowances, utilities... to run activities, we need to look for our own funding.)

The families of those who attend these centres are also affected, as many of them are in the lower-income bracket:

"Sebab pun sekarang ni ibu bapa kepada anak ni dia pergi kerja, bila seorang tak boleh kerja dia akan jadi kuranglah pendapatan."[35] (At the moment, the parents to these children would need to be employed and when one parent is out of work, their household income would decrease.)

"Waris-waris nak bayar kita macam mana? Sebulan RM35 pun tidak boleh."[36] (How would their extended family pay us? Even RM35 a month is not possible.)

As existing costs of operations and services are already high, it remains to be seen what the impacts of professionalising care services and the care economy would have on B40 communities.[37] This ties to the issue below.

II. Imbalanced and unequal development

As the existing socioeconomic landscape differs drastically from state to state and regions, the creation of a care economy will also amplify and reinforce these inequalities. This is particularly so if there are inadequate safeguards in the care economy framework, which are necessary to minimise and provide affirmative action for vulnerable and marginalised communities.

Many of these communities – for instance, those with low incomes and irregular incomes – are located primarily in semi-urban and rural areas. As poverty rates are higher and median wages lower in these areas, the populations there will be left out of accessible and quality care services. The quotes presented above highlight this disparity. This contrasts with urban areas and cities, such as Kuala Lumpur and Johor Bahru, that report higher household income and access to public services.[38]

It has been previously reported that among the 10 poorest districts in Malaysia, eight are in Sabah, one in Sarawak and another in Kelantan.[39] Principles and mechanisms derived from SDGs 1 (No Poverty) and 10 (Reduced Inequalities) serve as valuable guides to navigate through this challenge.

III. Availability of qualified and skilled workforce

Specific skills, training and qualifications are needed to run decent and competent services in care centres. Unfortunately, the availability of skilled and qualified social workers is not consistent across all care centres and premises. Furthermore, the variety of skill sets and competencies among workers differ from formal to informal centres.

Operators have also noted the difficulties recruiting qualified and motivated workers.[40] Young graduates, particularly, are not interested in the care sector. Those who are interested, whether from the younger or older age group, might not be qualified or motivated or both.

Social and care workers also need a clearer career pathway, as well as better remuneration in terms of wages and social security. They also need access to streamlined academic and vocational training tailored to the care service, while also being equipped with the tools to assess their competency and quality of their service. SDGs 4 (Quality Education), 5 (Gender Equality) and 9 (Industry, Innovation and Infrastructure) are pertinent to inform the discussion on this challenge.

IV. Lack of ecosystem for operators and recipients

Last but not least is the imperative to create a coherent ecosystem that facilitates the needs of care operators and recipients. However, such an ecosystem must be flexible and open enough to allow for autonomous actions on the ground level to cater to lived realities and needs.

This ecosystem – and the identification of its custodian's roles, jurisdictions and responsibilities – is a critical task. As the issues and needs of the vulnerable communities are diverse and multifaceted, cross-ministerial collaboration is also crucial at every level.[41] At present, initiatives on the care economy are led by the MWFCD. However, cooperation from other ministries – ranging from the Ministry of Economy to Ministry of Housing and Local Government, to MOE as well as Higher Education Ministry – are needed to ensure an organised flow of jurisdiction and command.

A functional ecosystem can serve as the foundation for a sustainable, inclusive and expansive care economy. Participants in roundtables hosted by the MySDG Centre for Social Inclusion of the APPGM-SDG have commented on how the existing workload on social services is unevenly carried by the Department of Social Welfare under MWFCD. To build a well-functioning and responsive ecosystem, changes must be made to the governance structure and paradigm of these various ministries. For this, the guidelines and spirit of SDGs 16 (Peace, Justice and Strong Institutions) and 17 (Partnerships for the Goals) are instructive to formulate a better perspective to address this challenge.[42]

9.5 Conclusion

This chapter opens with a discussion on the contemporary changes happening in Malaysia today and the social changes affecting Malaysian society. It also explores how these changes have shaped the concept of Malaysia's care economy.

It then discusses the context that informs the deliberations on the care economy in terms of the available literature published from a public policy perspective. Many of these papers were only published in the last two years (since 2023), although discussions on the care economy began much earlier in the post-Covid-19 landscape. The chapter then identifies one of the gaps in the literature, which is the lack of focus on how Malaysia's care economy ties back to the SDGs.

Next, the chapter discusses the basic structure of a care economy in Malaysia, its key characteristics and the benefits that a care economy would bring to care services in society. Many of the benefits highlighted seem to be favourable

particularly to those on the supply side of care. This chapter then assesses some of the critical challenges that remain for a care economy, many of which, incidentally, affect those primarily on the demand side.

In this fourth and final section, the chapter closes by presenting some concluding thoughts. To do so, there is a need to rehash the SDGs and their accompanying framework and principles. The APPGM-SDG's approach and school of thought to development continuously emphasises the need to understand "development" in its holistic and human-centric form.[43] Such a view contrasts with perspectives that consider development as merely material, financial and growth, one that is fixated on GDP and quantitative metrics.

I. Key takeaways and way forward

If development is conceived as such, then the care economy is tasked with the role of ensuring growth that is tailored to support the ideals of human development in Malaysia. The care economy itself, which focuses on social services and caring for vulnerable communities, ought to be constructed on the pillars of people, prosperity and partnerships, based on the values of leaving no one behind, justice and inclusivity.

This care economy would be situated in a broader and national mixed economy structure, where the privatisation and the commercialisation of basic services are prevented. Instead, basic and social facilities, including care services, are considered a public good and provided by the state to safeguard the welfare of the majority. The political economy of care would also focus on values, including fairness, democratic participation and eradicating deprivation, thus pivoting away from the orthodox approach of measuring national progress and economic growth through quantitative indicators only, such as income, GDP and foreign direct investment.

The launch of the MADANI Economic Framework by Prime Minister Anwar Ibrahim and its use as the anchor of all government policies and agendas has exemplified the government's efforts to practise social justice in the implementation of public and local programmes. These efforts are necessary and ought to be expanded.

Overall, there are three main takeaways in this chapter. First, the care economy can be designed as an engine of growth for the economy and guided by the paradigm of humane and justice-based development. Second, the care economy's purpose is to serve and benefit the most vulnerable and left-behind communities. Third, SDG and the SSE frameworks serve as instructive guides for the creation and running of a care economy that is sustainable, inclusive and intimate with local communities at the grassroots level.

II. Five basic recommendations

In line with these three key messages are five key recommendations, some of which might overlap with the recommendations presented in other chapters.

First, Malaysia needs to identify and acknowledge care as a public good and basic human right in accordance with the SDG principles. This is especially important for the vulnerable, such as the B40 group, who needs quality and accessible care services provided by the government. For these communities, care provisions ought to be incorporated into the social protection or welfare ecosystem delivered by the authorities.

Some of the measures can include: 1) restructuring of the savings system, in particular the Employees Provident Fund (EPF) and other income savings as well as retirement funds to include provisions for care expenditure and needs; 2) establishing a multi-stakeholder approach encompassing the government, NGOs or civil society, local communities, and operators to provide social protection and by extension, care infrastructure as well as services to those in need, in order to not be dependent on the state as the sole provider, and; 3) adopt different models of care that support universal and rights-based social protection instead of an industry or market-led care economy.[44]

Second, key stakeholders need to foster strong collaboration. This would mean building linkages and facilitating partnerships between the public sector, private sector and industry, as well as local communities. The government and the state remain the key entities tasked with facilitating these collaborations. This is because it is the government and the state that have the resources, reach and machinery to envision and implement social programmes that benefit the society at a national scale.

However, while the role of the government is central, there is also a need to review and update the structure of governance and methods of implementing public policy. It is no longer possible to utilise administrative structures of the 1970s and 1980s or those established later. Ideas cultivated during those decades should not be applied to address the personal troubles and public issues of society today. For new policies and systems to be implemented, such as a care economy, new modes of governance and public service delivery mechanisms are necessary. This is in line with the saying that "while we can have beautiful public policies in poetry, we need to have strong public administration in prose."[45]

Third, the government must establish a coherent legislative and policy framework for the care economy. This is fundamental to the expansion and maintenance of a vibrant and responsive care ecosystem. Besides, it would create a continuity of public policy programmes and implementation for the care industry, while instilling trust and confidence among investors as well as operators.

Fourth, in the longer term, other initiatives ought to be deliberated and implemented, one of which is to develop complementary and multipurpose models of financing for care targeting the B40, poor and rural communities. Such measures may include setting aside an identified amount of savings for care needs in EPF and other saving schemes, an allocation of funds for the elderly and subsidies for children.

Fifth, a crucial initiative is to build a competent and passionate pool of human capital through education and skills training. The education sector is a key enabler to produce passionate and competent social workers as well as care workers. For this, the SDG principles (goals 4 and 16) once again constitute the centrepiece of a national care economy that is guided by humane and justice-based development, and serve the needs of those in impoverished conditions, regardless of background, geographical location, ethnicity, religion and identity.

As we noted at the start, our society is undergoing fundamental and drastic changes. These changes are not only caused by internal dynamics and agencies present in our population, but they are also the result of external forces as well as changes that have occurred and are occurring at the global level.

For a care economy to operate within our national borders, dated ideas and approaches to governance and development are no longer sufficient. This includes our attempts to construct a welfare system that meets the changing needs of Malaysian society and, at the same time, aligns with the values of social justice, sustainability and inclusivity to leave no one behind.

The stakes for this transition are high. As a nation, Malaysia is still at its infancy. To ensure that the project of nation-building continues, it is vital that the needs of every person and society are addressed. This includes the provision of social care to ensure that everyone has a future in this country.

Endnotes

Introduction

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Conversations on the care economy in Malaysia
Roundtable discussions on
26-27 June 2024 at ISIS Malaysia

Growing the economy and meeting care needs of the Malaysian society
Care economy conference on
24-25 September 2024 at ISIS Malaysia

Malaysia is facing a care crisis. Rapid ageing, shifting family structures and rural-to-urban migration are straining an already underdeveloped care infrastructure. Unpaid care – predominantly carried out by women – represents an astounding RM379 billion in potential GDP, a figure that would make it Malaysia's second-largest economic sector.

This insightful publication transcends traditional views, positioning the care economy not as an expenditure but as a powerful engine for economic growth and social wellbeing. It explores how investing in childcare, eldercare, disability services and mental health support can drive inclusive growth, boost employment and improve national wellbeing.

Drawing on national data, international case studies and community perspectives, contributors highlight critical policy gaps and structural challenges. They offer four transformative lessons: professionalising the care sector, fostering inter-ministerial collaboration, developing a contextualised care framework and building a robust, inclusive care ecosystem for all generations.

As Malaysia develops its national and state-level care economy policies, this book provides timely insights to guide future strategies. It makes the case that care is not a private burden but a public good central to the country's sustainable development.

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