

# COVID-19, Long-Term Care, and Migration in Asia

**Azusa Sato and Helen Dempster**

## Abstract

Countries throughout Asia are experiencing rapidly aging populations and increasing life expectancy, leading to a large and growing demand for long-term care (LTC) services. Despite the shift to providing care within communities and at home, governments are struggling to provide enough LTC to meet demand. A large part of the constraint is the lack of available workers. While many countries in the region have migration schemes to bring in LTC workers, they are insufficient. At the same time, the COVID-19 pandemic has had an outsized impact on older people throughout the region, and has exposed deficiencies in the structure of migrant care labor. This report explores the impact of these three dynamics—LTC, migration, and COVID-19—on the current and future LTC workforce in the Asian region. It showcases 11 countries of origin and destination, including the demand for and supply of LTC, how it is financed and resourced, and where and how migrant workers are sourced. It puts forward recommendations for how governments throughout Asia can ethically and sustainably increase LTC worker migration; improve wages, working conditions, and recruitment processes within the sector; and learn lessons from COVID-19.

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This research was made possible thanks to a generous grant from the UK’s Foreign, Commonwealth, and Development Office (FCDO) through their COVID-19 Collective research program, managed by the Institute for Development Studies (IDS). The authors would like to thank Denielle Amparado, Emma Cameron, and Christelle Saintis for their excellent research assistance; our reviewers including Javier Guzman and Michael Clemens; our interviewees for their time and guidance; and our partner GaneshAid for their contributions to and dissemination of this work.

Azusa Sato and Helen Dempster. 2022. “COVID-19, Long-Term Care, and Migration in Asia.” CGD Policy Paper 260. Washington, DC: Center for Global Development. <https://www.cgdev.org/publication/covid-19-long-term-care-and-migration-asia>

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## Abbreviations

ADB	Asian Development Bank
ADL	Activities of daily living
ASEAN	Association of Southeast Asian Nations
BLA	Bilateral labor agreement
FCDO	UK's Foreign, Commonwealth, and Development Office
FDI	Foreign direct investment
GCC	Gulf Cooperation Council
IADL	Instrumental Activities of Daily Living
IBRD	International Bank for Reconstruction and Development
ILO	International Labour Organization
IOM	International Organization for Migration
KOICA	Korean International Cooperation Agency
LTC	Long-term care
MOM	Singaporean Ministry of Manpower
MOU	Memorandum of understanding
OECD	Organisation for Economic Co-operation and Development
OHCHR	United Nations Office of the High Commissioner for Human Rights
POEA	Philippine Overseas Employment Agency
PPE	Personal protective equipment
TFR	Total fertility rate
UHC	Universal health coverage
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
WB	World Bank
WHO	World Health Organization

## Executive summary

In recent years, migration for long-term care (LTC) has increasingly gained attention due to rapidly aging populations and the ensuing increase in demand for care. Not only are people living longer and having fewer children, they are also experiencing poorer health outcomes, changing the nature of the support they require. The COVID-19 pandemic has added to such woes, disproportionately impacting older people and straining limited human resources for LTC. While many countries see migration as one option to address supply shortages for LTC, migration patterns have shifted—some permanently—as governments suspended or changed requirements for the deployment of health workers, and border closures and lockdowns remain frequent and unpredictable.

This report, produced by the Center for Global Development (CGD), explores the impact of aging and COVID-19 on current and future health and care worker migration for LTC in Asia. Information was sourced through a combination of literature reviews and interviews with experts. The report covers 11 countries in Asia—of migrant origin and destination—which represent the majority of mobility in the region for LTC. They also show strong demographic predictors for expanded LTC needs, both now and in the future. The report presents the changes in, and the consequences of, aging experienced by these 11 countries. This includes emerging changes in the supply of care, which is primarily still provided by families and communities. Much of the supply of LTC is influenced by available financing, including insurance. Recognizing the shortfalls of relying on family-based care on the one hand, and cost of institutional care on the other, policymakers are focusing on creating enabling environments for LTC services to be delivered at, or near, home, termed ‘aging in place.’

The fact that care is provided by different people operating in different contexts with different levels of responsibility makes it difficult to understand the qualifications and skills required to work in the LTC sector. Further, the shortage of formal LTC workers in Asia impacts the availability and quality of care provided. Such supply deficiencies are exacerbated by the poor working conditions faced by LTC workers, including low pay and hazardous conditions, which have largely increased during the pandemic. Governments throughout the Asian region have taken initial actions to address supply challenges—including improving recruitment, retention, and upskilling—but are increasingly exploring alternative tactics, including sourcing labor from abroad.

Currently, much of the migration for LTC in Asia is intra-regional, predominantly from poorer Southeast Asian countries to richer East Asian ones. Such migration can have positive economic effects for the migrants themselves, their families, and their countries of origin and destination, especially if workers are able to access well-paid and rights-respecting roles. However, LTC migration can also have negative impacts, including abuse and exploitation, particularly for those employed in informal settings. Asia relies more on LTC workers in these informal settings, especially home-based workers, than any other region. These home-based LTC workers are a subset of ‘domestic workers,’ people who perform work in, or for, a private household or households. The informal nature of LTC work carried out in such settings makes it difficult for governments to regulate the provision of care and protect those who provide it.

The Asian region also presents an interesting case for LTC migration because of the significant number of immigration policies aimed at attracting LTC and domestic workers. These immigration policies often take the form of bilateral labor agreements (BLAs) or memoranda of understanding (MOU) with specific countries of origin, often tacked on to the broader immigration system. While seemingly providing a sound framework which addresses immediate LTC needs, relying on BLAs and MOUs can make it difficult to change regulations for the sector as a whole and to have any lasting or scaled impacts. The sustainability of addressing LTC workforce issues in this way is a valid and pressing question.

This report concludes with a number of key recommendations for policymakers in the Asian region involved in LTC and migration. They include tackling how to: ethically and sustainably expand migration for health and LTC; improve the wages, working conditions, and recruitment of migrant LTC workers; and promote LTC migration that is backed by better regulations. Such policies come at a time when increasing support for vulnerable populations, including those in need of LTC and their workers, is paramount as the region faces ongoing effects from the pandemic.

Addressing the challenges of migration for LTC requires a concerted effort from multiple actors representing multiple sectors and levels of care. The challenge has been made even greater due to COVID-19, but the pandemic also offers an opportunity to shift the status quo. To this end, we hope this report will be widely read and disseminated to all those interested and involved in LTC migration, such that together, we can make positive and impactful changes.

## Introduction

Countries throughout Asia have long used migration to meet their health workforce needs. In recent years, migration for long-term care (LTC) has increasingly gained attention due to rapidly aging populations and the ensuing increase in demand for care (Box 1). Between 2010 and 2050, in Asia, the number of people aged 60 or over will triple to 1.3 billion (UNDESA, 2017), fueled by increasing life expectancy and falling total fertility rates (TFR).<sup>1</sup> Asia is currently home to some of the oldest societies in the world: Japan, the People's Republic of China (China), Singapore, South Korea, and Taiwan (World Bank and UN, 2019). These countries demonstrate high dependency ratios and increasing demand for older persons' care.<sup>2</sup> The current supply of LTC workers produced by these countries is largely insufficient to meet this demand (ILO, 2015a). Many Asian governments have therefore looked towards

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<sup>1</sup>The 'total fertility rate' (TFR) is the average number of children a woman can expect to bear in her lifetime. In 2021, the global TFR was 2.4, approximately half of what it was in 1950 (World Population Review, 2021). The 'replacement rate' (the rate at which population levels are sustained) is 2.1.

<sup>2</sup>The 'dependency ratio' is the number of people in the labor market (the working-age population, or those aged 15–64) compared to the number of people outside the labor market (those aged 0–14, and over 65). It gives a measure of how many people are available to provide support (financially, through pension and tax systems) and physically (through labor) to those who need it. See [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Total-age\\_dependency\\_ratio](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Total-age_dependency_ratio).



migrant workers to fill this gap; in particular, from countries such as Indonesia, Malaysia, the Philippines, Sri Lanka, Thailand, and Vietnam.

### **Box 1. Defining ‘long-term care’ (LTC) and ‘older persons’**

Long-term care (LTC) involves a variety of services designed to meet a person’s health or personal care needs so that they can live as independently and safely as possible, as determined by the range of activities of daily living one can undertake without assistance (National Institute of Health, 2021). While LTC is relevant for people of any age, the need for such specialized care tends to grow with age. In some countries, LTC systems or benefits also cover children and adults with disabilities, although in most cases, the systems remain separate. Under these circumstances, we primarily focus our paper on LTC for people aged over 60 or 65 years, depending on the context and available data. We use the term ‘older persons’ to refer to this cohort, as experts argue the term ‘elderly’ is ageist and conjures up stereotypes of frail, sick, or physically dependent people (Avers et al., 2011). We label those who work primarily for older persons as ‘LTC workers.’

COVID-19 has had a unique impact on these dynamics. Older people are particularly vulnerable to the virus, and their care has presented significant challenges throughout the region. Migration patterns have shifted, as some countries initially suspended out-migration, including deployment of nurses and other medical workers, to ensure enough personnel remained at home (Lema, 2020; Jakarta Post, 2020). One country, the Philippines, looked to send workers overseas in exchange for vaccines (Morales, 2021). Such trends may persist, as countries of origin develop and look to safeguard their own LTC workforce and resources for future pandemics. Worldwide, Ministries of Health and Social Welfare have both been empowered domestically with increased resources and urgent mandates to address COVID-19, but have also had their attention diverted from non-urgent or non-COVID-19 care and support (WHO, 2021a). COVID-19 has also exposed the reliance that many high-income countries have on migrant health and care workers (Dempster and Smith, 2020), prompting a ‘global scramble’ for these workers, and a concurrent expansion in migration pathways to encourage their mobility (Omaswa, 2020). Many organizations, such as the World Health Organization (WHO), are worried this scramble will lead to the establishment of pathways for health worker migration that are neither ethical nor sustainable.

This research report, produced by the Center for Global Development (CGD) with funding from the UK’s Foreign, Commonwealth, and Development Office’s (FCDO) COVID-19 Collective, brings these shifting and fluid forces together. In particular, it explores the impact of aging and COVID-19 on current and future health and care worker migration for LTC in Asia. While literature exists on aging and human resources, migration, and COVID-19, to our knowledge there is not yet one piece that brings these aspects together, and with a regional focus.<sup>3</sup> In this paper, we largely focus on describing and analyzing migration from countries of origin to countries of destination in the region, given the scale and direction of current

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<sup>3</sup>For a global overview of these issues, please see Kumar et al., 2022.

migration flows and predicted future demand. That being said, we recognize that countries of origin will also increasingly require their own, enlarged, LTC workforce, and we therefore include examples from these countries where relevant and illustrative for Asia as a whole.

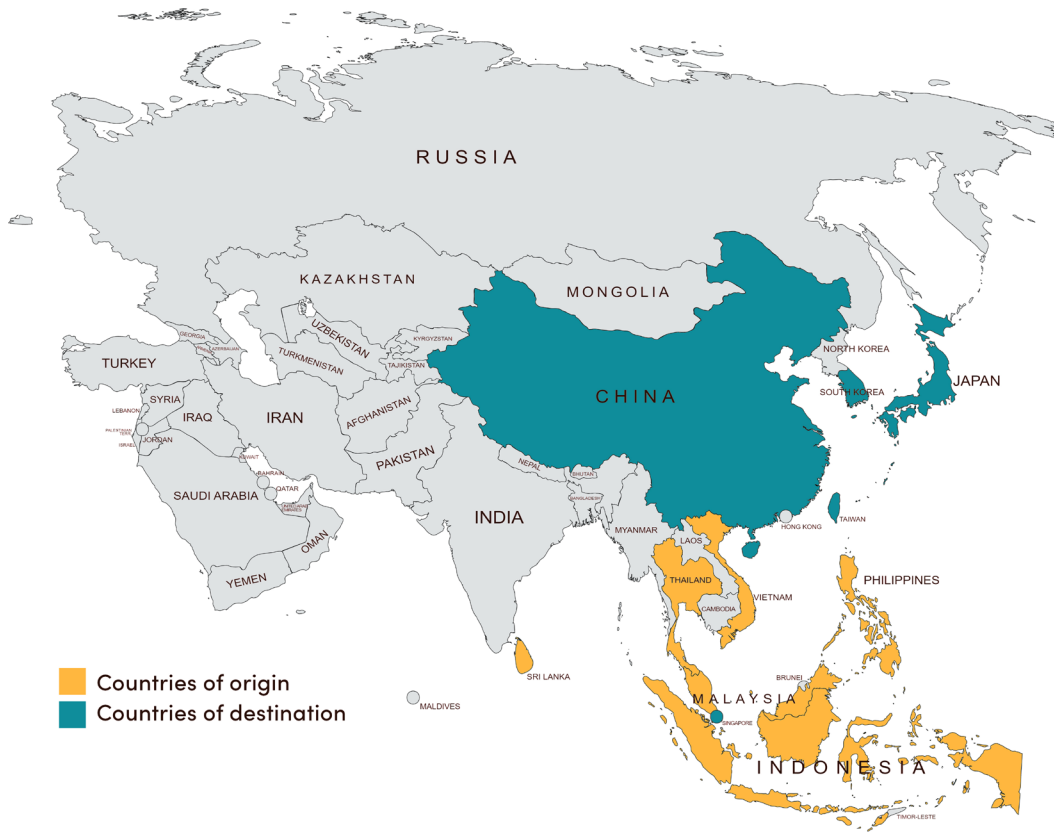
## **Methodology**

This review analyses demographic trends, LTC systems (including human resources), and migration patterns in the Asian region. We used a mixed methodology approach, starting with a desk review of key literature, including journal articles, reports, and studies, and news items. We corroborated and expanded on these results through interviews with experts and policymakers working in LTC, migration, and human resources for health throughout the region (see Annex 3 for list of interviewees). We also issued a survey, translated into six local languages, to garner policymaker feedback from our focus countries. Throughout, we use data from international organizations—such as the WHO, International Labor Organization (ILO), and Organisation for Economic Co-operation and Development (OECD)—and national governments and organizations.

While we acknowledge that most countries in Asia are experiencing changes in demographic patterns and are promoting some degree of migration for LTC, we concentrate this review on 11 Asian countries we consider as being most critical in their junctures (Figure 1). The five migrant ‘countries of destination’ we chose to focus on—China, Japan, Singapore, South Korea, and Taiwan—all exhibit low TFR and high life expectancies. We focus on these countries because, being higher income, they have the capacity to provide appropriate LTC financing mechanisms and robust coverage for the increasing health and social care needs of their older people. Yet, they face constraints, including the supply of LTC workers; part of their strategy to meet such care needs is the use of migrant workers.

Many of these migrant workers come from other parts of Asia—Indonesia, Malaysia, the Philippines, Sri Lanka, Thailand, and Vietnam—which we collectively term ‘countries of origin.’ International organizations such as the agencies of the United Nations (UN), multilateral development banks, and research organizations are actively supporting opportunities for younger generations in these countries to migrate to find safe and meaningful employment, to promote individual empowerment and broader economic development (IOM, 2020c). These younger generations also have high aspirations; a survey in 2019 found that 46.4 percent of people aged between 18 and 35 in Southeast Asian countries were interested in working overseas in the next three years (ASEAN, 2019). Hence, there exists a willingness on both sides to expand migration opportunities, including potentially for LTC work, in a way that is mutually beneficial. However, country of origin governments are increasingly wary of ‘brain drain,’ and the need to increase social investments in health, social protection, and education for healthy, active, and productive citizens at home (UNICEF, 2019). COVID-19 has enhanced this perspective, with many speaking of the need to ‘safeguard’ their own health workforce. Further, countries of origin are also experiencing population aging and will soon need to re-organize their LTC systems to prepare for this, including potentially reversing policies for the sending abroad of migrant workers.

**Figure 1. Focus countries of origin and destination**



*Note:* Created with mapchart.net.

## **Report structure**

Our report consists of five major sections. Section 1 outlines the key factors associated with demand and supply for LTC across our selected countries of origin and destination. We identify trends including declining TFR and increasing life expectancy coming together to create changes in the availability of the working population and increases in older persons' health needs. We then look at the LTC supply landscape to explore where care is provided and how it is financed. Together, we argue that there is a mismatch in demand and supply, such that there is an unmet need for LTC.

In Section 2, we explore the LTC workforce—the types of professionals, their skills, and required experience to take care of older people. Using available data, we show that there is a shortage of local LTC workers in our countries of destination which is creating the need to fill gaps with migrant workers. This is further explored in Section 3, which outlines patterns of mobility for LTC workers, where they end up working, and the positive and negative impacts of migration. In so doing, we look in-depth at the specific immigration pathways set up by countries of destination to facilitate such movements, as well as the support given by international and regional bodies on migration for LTC in Asia.

In the penultimate section, we turn to the impact of COVID-19 on LTC migration in Asia. COVID-19 has negatively impacted older people, LTC workers, and economies as a whole. Yet we find migrant LTC workers have been among the worst hit due to severe lockdowns and border restrictions, decreased economic opportunities, and increased workplace abuses. Both countries of origin and destination have seen changes in migration patterns and employment conditions and, in parallel, have put in place policies which support, as well as restrict, LTC migration.

In our final section, Section 5, we provide recommendations to policymakers throughout Asia who are responsible for supporting migrants during crises, organizing LTC, and implementing immigration pathways. In particular, these recommendations focus on ways migration for older persons' care throughout Asia could be expanded in a way that is ethical, sustainable, and provides a 'mutual benefit' for countries of origin.

## Section 1. LTC demand and supply in Asia

### Key Messages

- Total fertility rates are declining in countries of destination and origin in Asia
- At the same time, life expectancy is increasing (although many experience health problems later in life)
- These dynamics are leading to a lack of working-age people and an increased demand for LTC
- In Asia, care is provided predominantly in home- and community-based settings, and financed through different mechanisms, including insurance
- There remains a widespread unmet need for care, especially among women and those in rural areas

### Demand for LTC

Countries of destination throughout Asia are experiencing declining total fertility rates (TFR) and increasing life expectancy. As a result, these countries have reached the final stage of their 'demographic transition.'<sup>4</sup> Most of our countries of origin are still at the middle stages of the transition, with lower life expectancy and higher TFR. However, they are demographically catching up; by 2050, most too will be 'super aged;' over a fifth of their populations will be aged 65 or older.<sup>5</sup> The implications of low TFR are multiple, but one of the most concerning is the relatively high dependency ratio, which increases pressure on

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<sup>4</sup>The theory of 'demographic transition' posits there are four stages of transition in line with levels of economic development. As countries grow increasingly wealthy, birth and death rates generally fall. See UNFPA, 2021a.

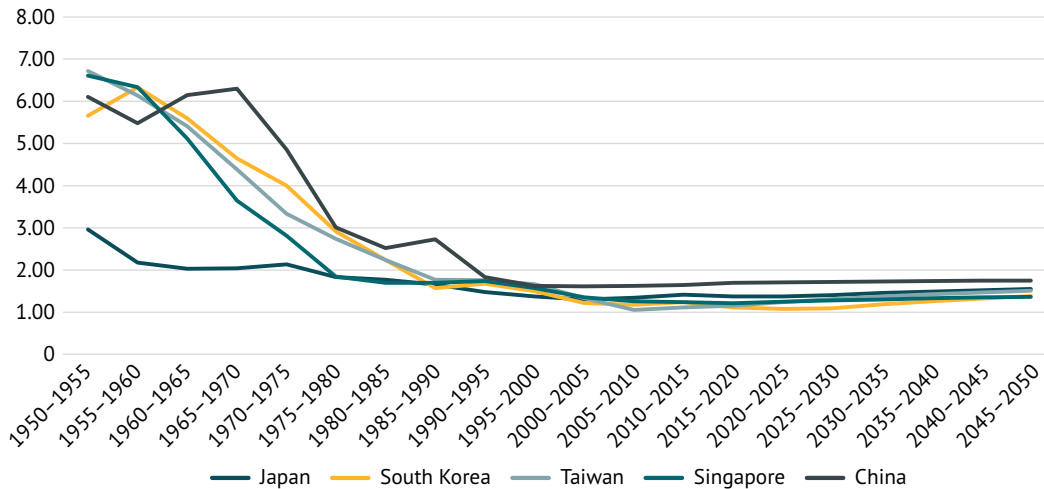
<sup>5</sup>Countries are usually broken into four 'aging' categories. 'Young' populations are where <7 percent of the population is aged 65 or older. 'Aging' populations are where 7–13 percent of the population is aged 65 or older. 'Aged' populations are where 14–20 percent of the population is aged 65 or older. 'Super aged' populations are where >21 percent of the population is aged 65 or older.

public finances, social security (including pensions), and creates demand for care provision. This can stall economic growth, lead to a decline in the labor force, and accelerate the need to reform the social security system, healthcare, and labor market (UNFPA, 2019).

**TFR are declining in countries of destination and origin**

Across Asia, our countries of destination—China, Japan, Singapore, South Korea, and Taiwan—are experiencing rapidly aging populations. Over the past seven decades, TFR have fallen steeply (Figure 2). Apart from Japan, in 1950, our countries of destination had a TFR well above five; by 1980, most were averaging around two. As of 2018, fertility rates in our countries of destination ranged between 1.11 and 1.69 (Annex 1), signifying TFR well below the ‘replacement rate’ of 2.1. Such statistics reflect individuals staying single for longer, often living in single-households, and opting to delay marriage and child-bearing. Individual decisions are intertwined with macroeconomic and societal changes, including the rapid urbanization of Asian cities (ADB, 2012), and with this, increased opportunities for women to enter and remain in the workforce, albeit still at alarmingly low rates when compared to men (ADB, 2015).

**Figure 2. Total fertility rates (TFR) in China, Japan, Singapore, South Korea, and Taiwan, 1950–2050**



Source: UNDESA (2019).

These countries of destination, which are among the richest in the world, have provided their populations with good health care and social protection. Robust health systems, including health technologies and family planning methods with better quality contraceptives and information, have supported lifestyle choices. At the same time, the financial burden of children, both directly and indirectly, has also deterred child-bearing (Fang and Lee, 2019).

Projections show low levels of TFR will remain steady well into the future and have not, to date, responded in a significant way to government policies designed to encourage

child-bearing, or ‘pronatalist’ policies (Box 2). These policies have focused on stimulating demand through incentives, both financial and creating more conducive environments for children and families, rather than relying on coercion. Here, China is an exception. China’s ‘One Child Policy,’ in place between 1979 and 2016, contributed significantly to their fall in fertility. But the policy is having long-lasting demographic impacts that the government is scrambling to reverse, including now obliging parents to have three children (BBC, 2021; Davidson, 2021).

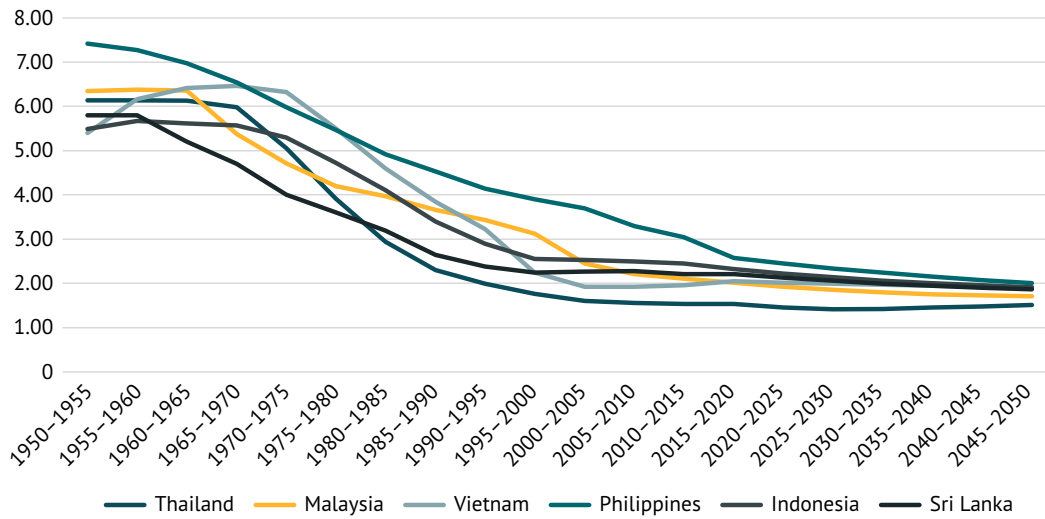
### **Box 2. Incentives to encourage childbearing: examples from South Korea and Singapore**

- South Korea. Starting in 2022, the South Korean government will provide 300,000 won (US\$275) every month to all new parents in the first year after the child’s birth, increasing to 500,000 won (US\$457) by 2025. The government will also provide a two million won (US\$1,827) bonus to expectant mothers to cover prenatal expenses from 2022. For families classed as low-income and with more than three children, the government will cover university tuition fees. Such incentives will replace earlier policies which provided 100,000 won (US\$91) for each child under the age of seven.
- Singapore. Singapore has attempted to raise fertility rates since 1987, with a combination of policies targeting financial incentives, parental support, and marriages. Despite these efforts, fertility rates actually *fell* between 2001 and 2018 (Tan, 2020). In 2018, existing pronatalist incentives were further enhanced to include financial support for assisted reproductive technology treatment; extensions to health insurance to cover serious pregnancy and delivery-related complications; paid maternity leave; the introduction of a tripartite standard to encourage employers to provide caregiving leave for unexpected caregiving needs; childcare subsidies, tax relief, and rebates; one-time cash bonuses; and grants for companies with flexible work arrangements (Sin, 2018). The Singaporean government also sells the idea of happy and fulfilled families, with dedicated policies offering a comprehensive suite of support measures and activities especially tailored for families (Government of Singapore, 2021).

*Sources:* Sajid (2020) and UN (2015).

The six countries of origin we examine in this report—Indonesia, Malaysia, the Philippines, Sri Lanka, Thailand, and Vietnam—are starting to simulate the patterns seen in our countries of destination. For example, the TFR of Thailand dropped from 2.52 to 1.53 between 1980 and 2018, which is comparable to China and Japan (Figure 3; UNDESA, 2019). Currently, TFR remains above two in all countries except Thailand and Malaysia, with the Philippines still above the replacement rate at 2.58. However, trends predict that TFR will fall below two in all our countries of origin by 2050, which should prompt a sense of policy urgency in these countries.

**Figure 3. Total fertility rates (TFR) in Indonesia, Malaysia, the Philippines, Sri Lanka, Thailand, and Vietnam, 1950–2050**

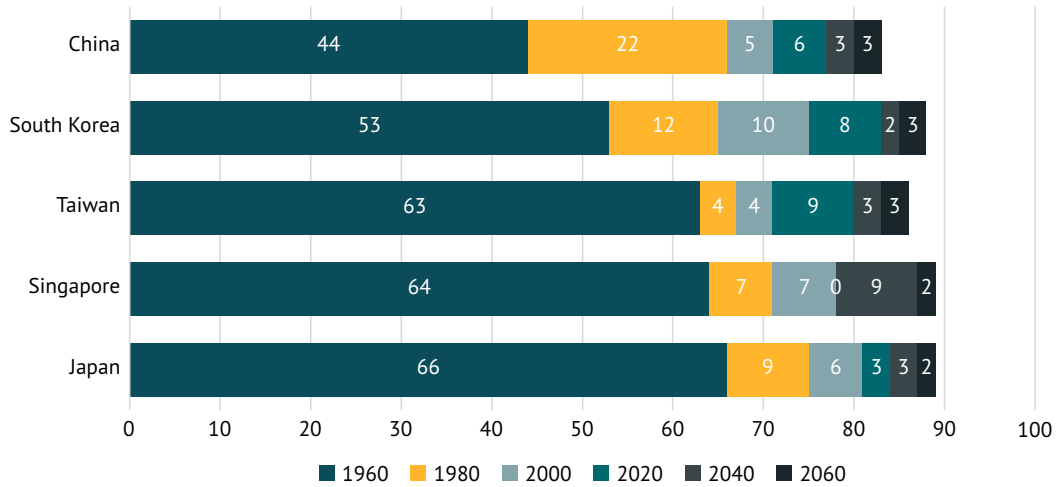


Source: UNDESA (2019).

### Life expectancy is increasing in countries of destination and origin

In addition to falling fertility, life expectancy has jumped dramatically in our countries of destination since 1960 (Figure 4). Thanks to better healthcare and basic standards of living and sanitation, both men and women in these countries can now expect to live well into their 80s, if not 90s. All countries see a continuous gain in life expectancy across the years, but gains have been particularly steep in China and South Korea, with China adding 22 years between 1960 to 1980, and South Korea 12 years in the same time span. By 2060, China is expecting to see an additional 39 years in life expectancy compared to its 1960 base (UNDESA, 2019).

**Figure 4. Life expectancy and additional years gained, in China, South Korea, Taiwan, Singapore, and Japan, 1960–2060**



Source: UNDESA (2019).

Note: In Singapore, between 2000 and 2020, there was roughly a one-year decrease in additional life expectancy, here noted as ‘0.’

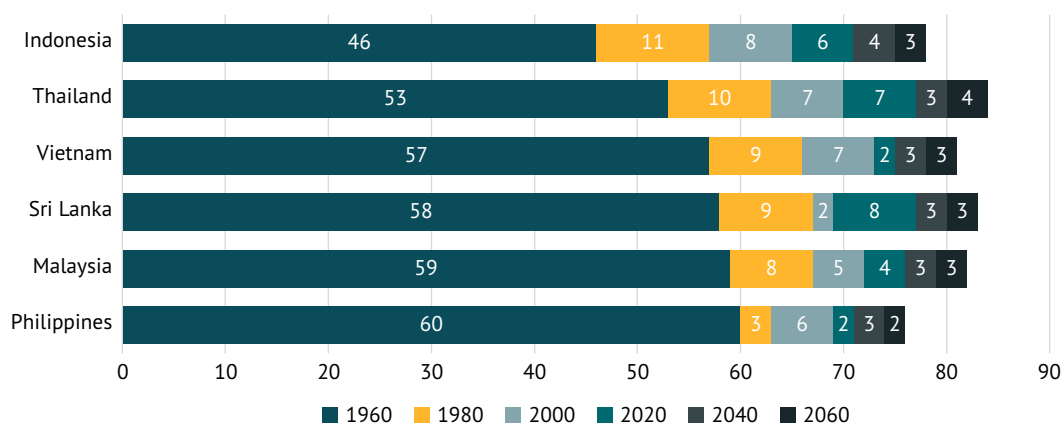
This trend has increased the percent of the population aged 65 and above throughout our countries of destination. In 2020, the most aged focus country was Japan, with 28.4 percent of the population aged 65 or above, followed by Taiwan (15.9 percent), South Korea (15.8 percent), Singapore (13.4 percent), and China (12 percent). Such trends loosely follow countries’ level of economic development, as well as social welfare provision (such as good quality health care): countries that reached higher levels of income sooner have seen better provision of health and hence higher life expectancy.

In our countries of origin, life expectancies in the 1960s were all below 60. Indonesians could only expect to live until 46, while Thais could expect to live until 53 (Figure 5). Yet the last sixty years has seen impressive gains in life expectancy, particularly in Indonesia, Thailand, and Vietnam. Today, life expectancies range between 71 (Indonesia and the Philippines), 75 (Vietnam), 76 (Malaysia), and 77 (Thailand and Sri Lanka).<sup>6</sup>

<sup>6</sup>Due to Thailand’s low TFR and high life expectancy, its old-age dependency ratio is 18.4, higher than even several countries of destination. The Thai government is actively considering policy implications as it sends workers abroad, as described in more detail in later sections.



**Figure 5. Life expectancy and additional years gained, in Indonesia, Thailand, the Philippines, Sri Lanka, Malaysia, and Vietnam, 1960–2060**



Source: UNDESA (2019).

The proportion of the population aged over 65 ranges between 5.5 percent (Philippines) and 13 percent (Thailand). Despite improvements in life expectancies, these countries still exhibit limitations in their health care systems and the provision of basic sanitation services, which has inhibited their ability to increase life expectancies as high as countries of destination. Most of these countries still show a ‘youth bulge,’ where a large share of the population comprises young adults and those within working age.<sup>7</sup> This presents an opportunity to reap the ‘demographic dividend.’<sup>8</sup>

### The impact of these dynamics

#### *A lack of working-age people*

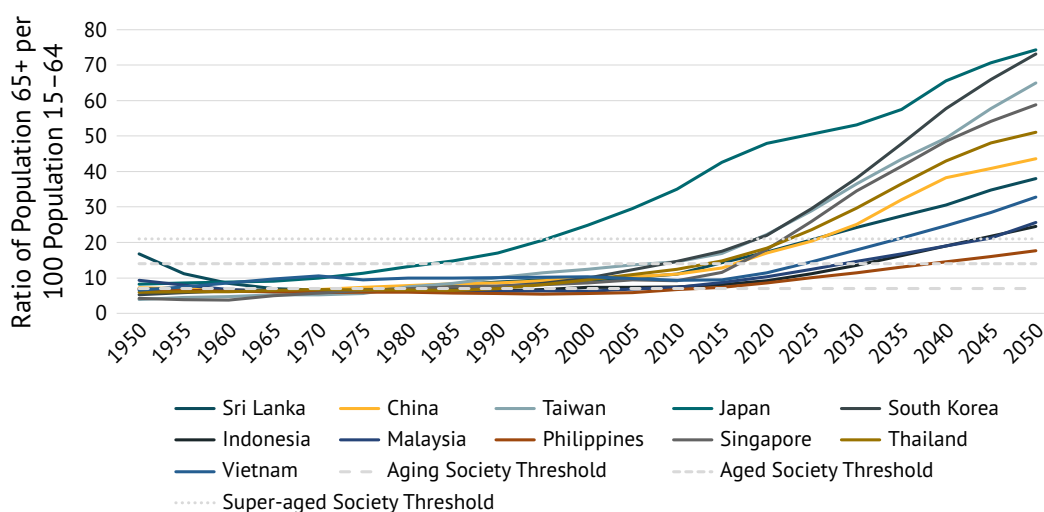
Together, falling fertility and increasing life expectancy have propelled richer Asian countries along the demographic transition (Drysdale, 2013). Without further interventions, countries of origin today will see demographic patterns on par with countries of destination within the next three decades. In our sample, all countries of destination will face negative population growth between 2045–2050 while all countries of origin will face negative population growth between 2075–2080 (not depicted), suggesting countries of origin are merely 30 years behind in the demographic transition.

<sup>7</sup>We do not extrapolate further about the consequences of a ‘youth bulge,’ suffice it to say that in a country with a youth bulge, the country’s dependency ratio will decline. Whether this will yield a ‘demographic dividend’ will depend on whether youth can find productive employment to raise per-capita income. See Lin (2012) for a discussion on Asian demographic dividends and Annex 1 for dependency ratios in our selected countries.

<sup>8</sup>The ‘demographic dividend’ is when countries are able to gain economically as households have fewer children, invest more per child, more women enter the formal workforce, and household savings rise (UNFPA, 2021b).

Overall, the most critical impact of lower TFR and higher life expectancy is the dependency ratio, or the number of older people to working-age people.<sup>9</sup> The dependency ratio has increased since 2010 in all countries in our analysis (Figure 6). At 48, Japan has the highest old-age dependency ratio as of 2020, but projections show South Korea will soon surpass this. A high old-age dependency ratio places a higher burden on the working population and the state to care and provide for older people. The implications of this include reduced tax revenues, especially from income tax; increased government spending on pensions and specialized health care; and potential labor shortages, especially for LTC.

**Figure 6. Old-age dependency ratio growth in China, Indonesia, Japan, Malaysia, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Thailand, and Vietnam, 1950–2050**



*Source:* Own graph using data from UNDESA (2019).

In line, retirement ages, which are slow to rise, are not keeping up with demographic changes. While many older people are still able to work, mandatory retirement ages are relatively low. For example, the current average age of retirement in China is 54, a standard that was set in 1950 when the average person was expected to die before that age (The Economist, 2021a).<sup>10</sup> Japan’s retirement age for public sector workers will rise by one year every two years starting in 2023, reaching 65 by 2031 (Nippon.com, 2021), but given average life expectancy is 85, many will retire with two decades or more of life remaining. This affects both the income of older people as well as welfare state provision. Similarly, unemployment can have negative social effects as many older people find themselves marginalized from society and isolated at home (Barrenetxea et al., 2021).

<sup>9</sup>The ‘old-age dependency ratio’ is the number of persons aged 65 and over and then number of persons aged between 15 and 64 (the ‘working-age’ population). It is normally expressed per 100 persons of working age. See <https://ec.europa.eu/eurostat/web/products-datasets/-/tps00198>.

<sup>10</sup>Figure 2 suggests that, even in 1960, life expectancy in China was 44. In 2019, China’s life expectancy was 77.

### *Changes in older persons' health needs*

As countries have progressed along the demographic transition, the number of older people with disabilities and morbidities, both physically and mentally, has increased. Older people are more likely to need support to carry out 'activities of daily living' (ADL) such as mobility, washing, cleaning, and feeding; and 'instrumental activities of daily living' (IADL) such as transportation, managing finances, meal preparation, and house maintenance. Older people are more likely to experience non-communicable diseases such as strokes, cardiovascular diseases, diabetes, hypertension, and Alzheimer's disease or related dementia. As people get older, the odds of suffering from many diseases at once (comorbidities) also increases, especially for those over 65 (Divo et al., 2014; Feng et al., 2020a). Mental and physical health are closely interlinked, with actual and perceived social isolation and loneliness closely associated with increased risk for early mortality (Holt-Lunstad et al., 2015). All in all, therefore, the general increase in life expectancy has led to an increase in the number of years lived in an 'unhealthy' state, which is negatively impacting quality of life and levels of life satisfaction (Sato et al., 2002).

The increasing need for health care and social care support is also related to the use of LTC: studies have found ADLs and IADLs are significant predictors of the need for nursing home care, paid home care, and use of hospital services (Edemekong et al., 2021; Wiener et al., 1990). Utilization of LTC will therefore shift dramatically across Asia in the coming years. For example, Ansah et al. (2013) estimate that, in Singapore, the proportion of older people aged over 60 living at home with five or more limitations on ADL will double by 2030, and the number of hours of family care for older people will increase by 41 percent to 29 to 41 hours per week, equivalent to a full-time job. Such figures predict a looming gap in the supply of people to provide this support.

## **Supply of LTC**

### **Care is provided both in the community and in institutions**

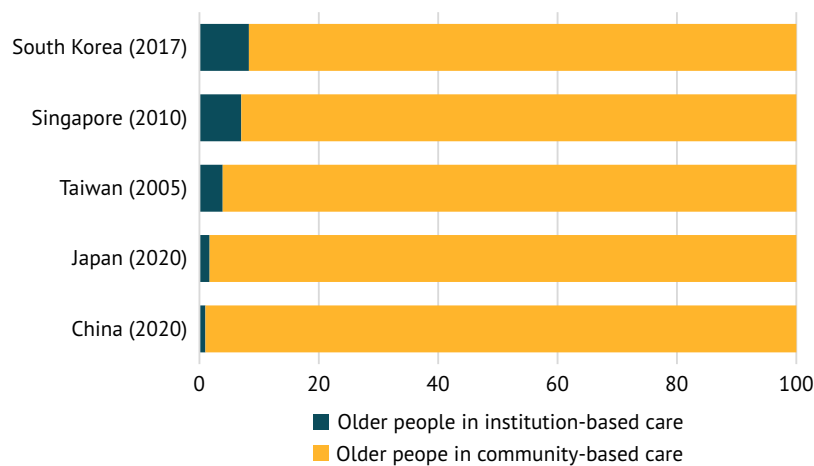
The characteristics of the care recipient, site of service provision, and type of care all determine who the key providers are and who pays. While care can be provided by different types of institutions (the state; families/households; markets; and non-profit organizations including non-governmental and civil society organizations), the boundaries between them are neither static nor clear-cut (King-Dejardin, 2019; Razavi, 2007). However, overall, LTC can be classified as either community- or institution-based:

- **Community-based care** refers to all forms of care that *do not* require older persons or persons with disabilities to reside permanently in an institutional care setting. It includes in-home or family-based care (provided by both formal and informal workers, see Section 2) and community and day centers.

- **Institution-based care** is delivered in assisted-living facilities and nursing homes. Respite care provides short-term care to relieve unpaid carers and can be provided in people’s homes, community and day centers, or residential facilities (ILO and OECD, 2019).

While data is challenging to find, in all our countries of destination, there is a relatively small percentage of older people living in institutional care, with South Korea and China on either extreme (Figure 7). The introduction of LTC insurance in South Korea led to an increase in LTC infrastructure, which ensured LTC was institutionally focused. By 2017, 8.3 percent of older people were living in institutions, the highest in Asia (King-Dejardin, 2019). However, this trend may be reversing, with more recent data indicating less than three percent (London School of Economics, email to author November 22, 2021).<sup>11</sup> In China, less than one percent are using institutional care, following central government policy targets to increase community-based care (ibid.).

**Figure 7. Percent of care provided in community-based and institution-based care settings in South Korea, Singapore, Taiwan, Japan, and China**



*Sources:* South Korea (King-Dejardin, 2019); Singapore (Wong and Chan, 2020); Taiwan (Chou et al., 2015); and Japan (Japanese Statistics Office, 2020). Estimates for China are based on government statistics which show the number of people aged over 60 in residential care is 2.1 million, vis-a-vis approximately 264 million older people (Ministry of Social Affairs China, 2021).

Therefore, the vast majority of older people in Asia are cared for in the community (Yeung et al., 2018). Policymakers have drawn upon Confucianist ideas including ‘filial piety’—which revere older people and strong family ties—to position children and the family as primary caregivers (Yi et al., 2016; Zhan and Montgomery, 2003). This is in sharp contrast to many other countries, including those with similar levels of income, which see an increasing trend of older people living alone. In 19 OECD countries with available data, 39 percent of LTC recipients are cared for in an institution; the probability of living in an institution among

<sup>11</sup>The Chinese government has set targets requiring 90 percent of older people to seek care at home (informally or formally); seven percent in the community; and three percent in institutions (Feng et al., 2020b).

OECD countries increases with age (OECD, 2021).<sup>12</sup> 61 percent are cared for at home, with many living alone (for example, in Denmark, 46 percent of older people live alone) (ibid.).

In seven Asian countries—Cambodia, China, Indonesia, Myanmar, the Philippines, Singapore, and Vietnam—LTC is the legal responsibility of children and the family (Box 3). The power and enforceability of such laws is questionable. In China, for example, punishments were not outlined (Dong, 2016). Some argue that legal provisions fail because both children and older people choose to follow models of LTC that can better deal with major medical conditions, as well as end-of-life care, which are often provided at institutions (Woo, 2020). As such, both older people, and those who are supposed to take care of them, recognize that without more formal services older people may have their care needs being missed or unfulfilled.

### **Box 3. Legal provisions for LTC as a responsibility of children and the family in selected Asian countries**

#### China (People’s Republic of China, 2012)

The Law on Protection of the Rights and Interests of the Elderly (2012 Revision), also known as the Filial Piety Law), stipulates that “the elderly shall be provided for mainly by their families, and their family members shall respect, care for and look after them.” Adult children must look after parents aged over 60 (Dong, 2016), covering medical expenses for those in financial hardship, providing mental comfort, attending to any special needs, and arranging housing. If they are not able to provide this care they may, with the consent of the older person, commission other individuals or institutions (such as community or older people organizations) to bear responsibility. China also recently introduced a law which allows older people to sue children for neglect (Rhanasinghe and Min, 2013).

#### Vietnam (Socialist Republic of Vietnam, 2009)

Vietnam’s Law on Elderly People (2009) states that “the elderly’s families shall take the main responsibility in taking care of the elderly,” including economic assistance, meeting basic needs for meals, clothing, housing, travel, health, study, culture, information, and personal communication. Only if individuals are unable to fulfil or attend directly to older people may they seek support from other authorized bodies, with the consent of the concerned older person.

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<sup>12</sup> Austria, Denmark, Estonia, Finland, Germany, Greece, Israel, Italy, Korea, Latvia, Lithuania, Luxembourg, New Zealand, Norway, Portugal, Slovak Republic, Spain, Sweden, and Switzerland. OECD Long-Term Care Resources and Utilization dataset, retrieved January 21, 2022. Available at <https://stats.oecd.org/Index.aspx?QueryId=30140>.

### The Philippines (Republic of the Philippines, 1987)

Article 15 Section 4 of the 1987 Constitution states: “it is the duty of the family to take care of its elderly members while the State may design programs of social security for them.”

### Indonesia (Republic of Indonesia, 1998)

The Old Age Welfare Law of 1998 stipulates that older persons’ welfare should be shared by the government, society, and families of older people. Interestingly, responsibilities run both ways: older people are themselves directed to “guide and provide wise advice based on his/her dignity and experience, especially within his/her family,” and “set a good example in life for their successors.”

### Malaysia

The Malaysian government highlights the importance of intergenerational solidarity among families to actively support older people (Loichinger and Pothisiri, 2018). The National Family Policy of 2010 provides a framework for national development which puts family at the center of all socioeconomic development efforts. In line, special family support services and family friendly initiatives (such as childcare leave, bringing women back into the workforce, and flexible working arrangements) have been put in place (Ishmail, n.d.).

*Source:* Johns Hopkins (2012).

Others argue that enforcing these laws will lead to economic difficulties. In countries where rural to urban migration is frequent and wage disparities are high, parents migrate for work, leaving grandparents to care for grandchildren. Consequently, multigenerational structures are not necessarily permanent and are often dictated by employment opportunities (Hoang et al., 2015). On the demand side, older people in China have commented on how they do not wish to be a burden on their children (Gallagher and Dunn, 2019). Similarly, in the Philippines, over 80 percent of older people support the idea of institutions for older people (Abalos, 2019). This suggests that Confucian concepts are weakening and promotion of filial piety through legislation may not sufficiently fill supply gaps.

Recognizing the shortfalls of relying on family-based care on the one hand, and cost of institutional-based care on the other, policymakers are focusing on creating enabling environments for LTC services to be delivered at, or near, home, with the support of a range of public and private sector service providers. This is termed ‘aging in place’ and caters well to older people’s wishes (Lin, 2021; Yu and Rosenberg, 2017), while simultaneously creating social cohesion by bringing different generations together in familial and communal settings (Box 4).

#### **Box 4. Examples of ‘aging in place’ in Asia**

China. “Virtual Elder Care Home and Elder Care Home without Walls” (Feng et al., 2012)

These programs feature home care agencies providing a wide range of personal care and homemaker services in older persons’ homes. Services are initiated by phone calls to a local government–sponsored information and service center, which then directs a qualified service provider to the older persons’ home.

Singapore. “Kampungs” (Hassani, 2020)

The Government of Singapore has built public housing which integrates a mix of social, healthcare, communal, commercial, and housing facilities tailored for those aged 55 and over. The government commissioned architecture firms to design modern but functional buildings and community areas. One such building, nicknamed the ‘club sandwich’ design, won 2018’s Building of the Year Award at the World Architecture Festival in Amsterdam. Supplementing this, older people can participate in free classes and volunteer in the senior center within the complex, as well as socialize at the local hawker center.

In support of ‘aging in place,’ non-profit providers and volunteer networks including charitable, religious, and community-based organizations and committees are gaining in popularity (King-Dejardin, 2019; ADB, 2021b). The government can sponsor community volunteers and clubs for older people to provide care for those in need (ADB, 2020a). Some community organizations are not specifically focused on older people, but emphasize community strengthening, while others look for common grounds such as religious beliefs to set their visions and ethos for mutual support.

Finally, the state is critical in providing services directly, subsidizing, or contracting out services. In general, the government tends to provide basic levels of health and social care and retains responsibility for overseeing all institutions that provide LTC as the regulator and standard setter (Royal Commission into Aged Care Quality and Safety, 2020). That being said, the extent to which the government intervenes differs by ideology and availability of resources. In many cases, the financing of LTC, particularly insurance, shapes the extent to which the government provides that care (discussed further below). For example, in Japan, institutional residential services are predominantly public or non-profit, as private residential services are only partially covered by insurance (ibid.).

In the countries of origin where LTC financing is still premature, much is privately financed, but the government also provides services directly. For example, the Philippines has a network of homes for older people, although use of such formal services is limited (Badana and Andel, 2018); as of 2015, there were about 2,500 older Filipinos residing in home-care institutions (Abalos, 2019), the majority of which (88 percent) are privately run (Department of Social Welfare and Development, 2019). Indonesia also offers various nursing-home services sponsored by the government, as well as the nonprofit and private sectors (Sumini et al., 2020). In Malaysia, the government provides both residential and non-residential care to older people under the Ministry of Health and Ministry of Women,

Family and Community Development (Hasmuk et al., 2020) but community-based LTC is unregulated. At the state level, Islamic family law provides assistance for older people as well (Loichinger and Pothisiri, 2018).

### **Care is financed through different forms of financing**

LTC provision depends heavily on the source of, and ability to, finance. The extent to which the government intervenes and supports health and LTC expenditures is dependent on resource availability and prioritization between different expenditure programs and distributive policies, among others. However, the basic notion of insurance and health financing generally, whether for LTC or health, is to raise sufficient revenues which can be shared, or pooled, between high and low risk populations, for the purchase and delivery of services. For both health and LTC, this means ensuring that, at times of need, the poorer, more vulnerable, and sicker populations (such as older people, younger people, and those with low incomes) can ultimately receive care without falling into financial difficulties.

All our countries of destination have created health insurance or financing schemes to ensure older people and their families are protected from catastrophic LTC expenditures. Politicians and policymakers have taken advantage of rising public support for such policies, often enacting legislation related to LTC financing at opportune times (Kim and Kwon, 2021). Ultimately, governments also hope increasing financial and social protection will positively impact fertility, especially by relieving the burden of care for women and families (UNFPA, 2019). Annex 2 lays out an overview of LTC support and financial arrangements for our countries of destination, which is briefly explained below.

Japan, South Korea, and Taiwan have developed an ‘inclusive social insurance model’ with a high level of public support for social equity and redistributive social policies, such as universal health insurance and pension schemes (Chien, 2018; Peng and Wong, 2010). Both Japan and South Korea see LTC provision as an extension of UHC, but use the term ‘LTC insurance.’ Japan, the first country in Asia to conceptualize LTC insurance (in 1997, launched in 2000), emphasized it should be based on three concepts—support for independence, social insurance, and a user-oriented system—with the aim of shifting the burden of family caregiving to social solidarity (Yamada and Arai, 2020). South Korea has taken a similar stance following Japan’s model, with a heavy lean towards private sector service delivery (Peng, 2012; 2018).

More recently, Taiwan and Singapore have also created their own financing mechanisms. They have tended towards a more market-based LTC model, characterized by individualized social protection through incentivized private savings. Taiwan’s model, while sharing similarities with Japan and South Korea, long delayed implementation of LTC insurance (Chien, 2018). Under the more recent ‘LTC 2.0 Plan’ put forward in 2017, a social insurance system (i.e. funded through mandatory pay-roll premiums) was promoted. However, the Plan has not yet passed into law, leaving Taiwan to largely depend on private financing to fund LTC services, including hiring foreign care workers at home out of pocket (Yeh, 2020). As such, there is limited reliance on institutional care (Lin, 2010). Singapore follows the most



liberal market model and, much like its health insurance coverage, LTC insurance emphasizes individual responsibility, with premiums being paid into three types of dedicated funds. Individuals are subsidized following means-testing, and are able to select services from a range of providers.

Across these four countries of destination (Japan, Singapore, South Korea, and Taiwan), insurance schemes cover institution- and community-based (including home-based) care, provided publicly or by private service providers. No scheme covers everything, however out-of-pocket costs appear relatively low.<sup>13</sup> In South Korea, the average out-of-pocket cost per month for home-based care is about US\$172 and for institution-based care is US\$316 (Ga, 2020). In Japan, people categorized to have low-income do not pay more than \$354 a month, and a cap also applies (Matsuda et al., 2020).

In contrast, China does not have a nationwide LTC insurance scheme. Without nationwide insurance, LTC remains unaffordable for many. A 2013 survey of older people from ten Chinese cities showed the average cost of adult day services (1,500 Yuan per month, approximately US\$235) was more than half the average pension (2,500 Yuan per month, US\$391) (Wiener et al., 2018). However, since 2016, 15 cities have carried out LTC insurance pilots, signaling the government's intentions to eventually roll-out more comprehensive and wider schemes. One, in Shanghai, showed insurance reduced the length of stay, inpatient expenditures, and health insurance expenditures in tertiary hospitals by 41 percent, 18 percent, and 11 percent, respectively (Feng et al., 2020a).

As insurance and finance schemes have evolved, they have started to consider the eligibility of care provided at home. Some mechanisms, such as those supported in South Korea, provide a limited cash allowance as part of the package, allowing beneficiaries to pay for complementary LTC care directly, including for domestic and migrant workers (Peng and Yeandle, 2017). Yet, national LTC systems, including those supported by LTC insurance, are not necessarily aligned with schemes which encourage migration for LTC provision. Under Taiwan's foreign live-in care worker scheme, for example, workers are unable to gain permanent residency even after many years of service (Yeh, 2020) (see Section 3 for further details). To address shortages in LTC workers, policymakers will need to take a multi-pronged approach including strengthening financing schemes for LTC workers in family- and community-based settings, enabling migrant workers to count their years of live-in care experience towards longer term residency, and considering ways that insurance can better reimburse out-of-pocket payments for care costs incurred at home.

Aside from LTC insurance, governments have put in place other insurance-type financing mechanisms to take care of older people. For example, Singapore has individual savings schemes to support out of pocket expenses, tax relief (including for hiring foreign domestic

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<sup>13</sup> A review among OECD countries shows that even for as little as 6.5 hours of care per week for people with low needs, the total costs of home LTC services would represent more than half of the disposable income of an older person with a low income. However, LTC financing mechanisms buffer users from high out-of-pocket expenditures and as such, financing mechanisms are critical for affordability (OECD, 2020e).

workers), and subsidies for families to co-reside and to purchase care in the private market, as well as provision of community activities to keep older people active within their neighborhoods.

Overall, while LTC financing schemes in countries of destination are evolving to increase financial protection for older people and their families, schemes are not yet comprehensive enough, and do not sufficiently address supply constraints, especially for human resources. Among the least thought out are provisions to finance migrant care workers. We address this in more detail in a later section.

## **Unmet need for LTC**

Is the supply of LTC keeping up with increasing demand or is there an ‘unmet need’?<sup>14</sup> While global data does not exist, national data does show gaps in provision of, and access, to LTC services in low- and middle-income countries (WHO, 2021b). There are many reasons as to why someone may not be able to access LTC, including problems with affordability, acceptability, accessibility, and availability (WHO and IBRD/WB, 2021). For example, according to Scheil-Adlung (2015), 32 percent of people in Japan and 91 percent of people in China are not able to afford the US\$1,460.80 purchasing power parity (PPP) per year required to pay for LTC services. In contrast, in South Korea, the presence of a comprehensive insurance scheme has made care more affordable.<sup>15</sup> In Section 2, we explore how a lack of staff could contribute to an unmet care need.

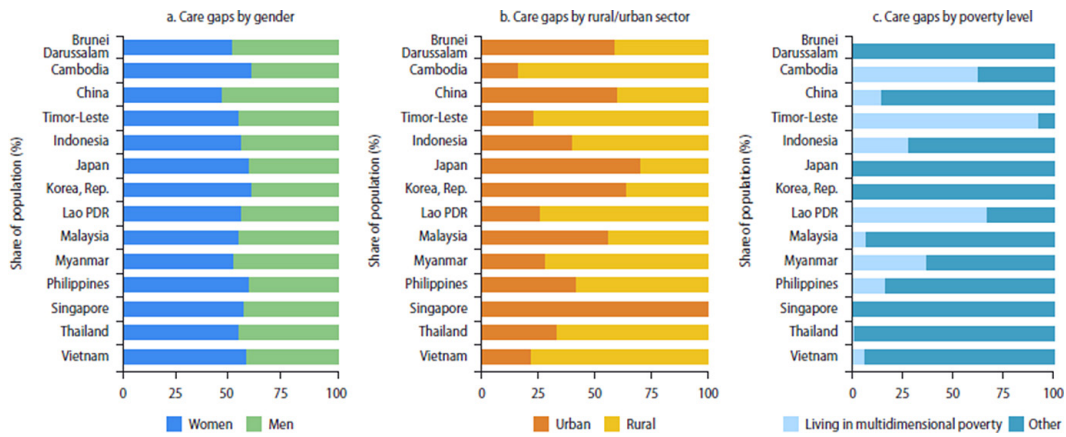
These trends are reflected in a survey carried out in 2012 across Asia which found that, on average, 50 percent of people experienced an unmet need for care (Research Base, 2012). Such gaps are greater for those living in rural areas, women, and the poor (Figure 8). For example, there is a disproportionately high unmet need for care among women in Singapore, Japan, and South Korea. Care gaps in rural areas are particularly high in countries like Indonesia, Philippines, Thailand, and Vietnam. Those living in poverty are more likely to experience a significant unmet need for care, especially in our countries of origin (particularly Indonesia, Malaysia, Philippines, and Vietnam) rather than in richer countries of destination (such as Japan, South Korea, and Singapore).

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<sup>14</sup>In this paper, we use the term ‘unmet need’ to refer to situations where LTC is unavailable or insufficient to meet the needs of an individual (WHO and IBRD/WB, 2021).

<sup>15</sup>The relative threshold for a ‘lack of financial resources’ is US\$1,461,80 PPP, deriving from the population weighted median expenditure in a group of 34 countries in the Americas, Asia and Pacific, and Europe.

**Figure 8. Older persons' unmet need for care among rural areas, women, and the poor**



Source: Research Base (2012).

Here, China provides a good example. In 2015, researchers at Beijing University released the results of a longitudinal survey of 2,860 older people. Approximately 17 percent of people aged 60 or older who were in need of care did not receive it, with these effects being worse if the older person was a woman or lived in a rural area. The vast majority, 94 percent, were looked after by relatives including spouses, children, and extended family. Less than six percent paid for services, such as those provided by the government, private sector, community, or domestic workers. Those who paid for care were more likely to live in urban areas and be male. The survey notes that family-based care cannot fully meet the demands of older people's health and long-term medical care requirements (Dong et al., 2021).

Both of these surveys were conducted almost ten years ago. Since this time, the demand for LTC and the inability of LTC systems to meet this demand has increased. As populations throughout the Asian region continue to age, policymakers must pay increasing attention to ascertaining where care is needed (both within and between countries); who will provide this care; how it will be financed; and the impact of these dynamics on older people and their carers. This report focuses predominantly on quantitative aspects of care, including the numbers of people available to provide care, though further attention must also be paid to the *quality* of care provided. Finally, the impact of COVID-19 on this unmet need for care is likely to be substantial and prolonged. We explore this in more detail in Section 4.

## Section 2. The LTC workforce

### Key Messages

- LTC is delivered by people operating in different contexts and with different levels of responsibility, making it difficult to understand the qualifications and skills required
- Globally, there is a shortage of formal LTC workers, which is having impacts on the availability and quality of care provided
- Policymakers in Asia have explored different ways to increase the supply of LTC workers, with little success
- Hence, many have looked to encouraging the migration of care workers, particularly inter-regionally, to meet this shortage

As discussed in the previous section, LTC can be delivered in the home, in the community, and in institutional settings. All require a dedicated and skilled workforce that is lacking in most countries around the world. Despite this demand, human resources for health, and LTC in particular, is rarely focused on or researched. We argue this is for four main reasons. First, both the practice of and policy surrounding LTC is nascent, with many governments only recognizing their critical importance in the past two or three decades. Second, the sector is multisectoral in nature, with elements of health mixed with social care, which makes it difficult to understand the skills workers need in different contexts. Third, much of the care given blurs boundaries between informal and formal, professional and non-professional, and may not be classified as LTC, leaving gaps in official reporting. Fourth, LTC is predominantly a sector characterized as ‘women’s work’ and therefore undervalued (Ferrant et al., 2014). As a result, there is a significant need to explore who provides LTC and what gaps may need to be filled by migrant workers.

### **LTC is delivered by a variety of people with different levels of skills and experience**

It can be difficult to ascertain the skills and experience required to operate as an LTC worker as the tasks they are called upon to perform and the location of those tasks varies wildly, even within the Asian region. The OECD usually classifies LTC workers into ‘formal’ and ‘informal’ workers:

- **Formal LTC workers** comprise two main categories—nurses and personal care workers—with the latter including people providing LTC services at home or in institutions (other than hospitals) who are generally not qualified or certified as nurses (OECD, 2020a). Other types of formal LTC workers include those specialized in certain aspects of care, such as occupational therapists for management of occupational needs, physiotherapists for physical rehabilitation, speech therapists for speech disorders, geriatricians for LTC, and general health professionals such as medical doctors. Care managers and social workers provide a critical link between different care and service providers, supporting clients with personalized care management.

- **Informal LTC workers** are those who are not formally contracted or paid to provide services. Family, friends, and neighbors tend to fall within this informal category. Volunteers can fall between the formal and informal definition, depending on whether stipends are paid and training or certifications are made available or mandatory.

Details on the number of workers in these situations is provided later in the paper. Overall, it is thought that the number of informal caregivers (especially family) is declining, their increase is at a slower pace than the number of dependent older people, and they are facing limitations in their capacity to provide adequate care (OECD, 2011).

The tasks that these workers are called upon to perform vary, as do their minimum qualifications and training requirements (see Table 1). In most high-income countries, LTC workers require some level of vocational training, or a high school or technical qualification certificate (OECD, 2020a). That being said, many workers are able to operate without such qualifications. For example, a comprehensive survey of LTC workers in 460 institutions in Beijing, China, shows only 59 percent had a caregiver certificate, 35 percent did not have the certificate but had received training, and 6 percent had neither (Dong et al., 2021).

**Table 1. Types of human resources for LTC**

Role	Key Tasks	Minimum Qualifications and Training Required to Practice (Generalized)
<b>Formal</b>		
Personal care workers/ assistants <sup>16</sup>	Assisting in carrying out ADL, IADL, personal care, some nursing care, referring and linking to medical care and communication with families	Few weeks' training
Occupational therapists	Diagnosis and management of occupational needs	Diploma
Care managers and social workers	Personalized care management; linking different resources and care providers	Diploma or bachelor's degree in relevant field
Nurses (e.g. registered, technical, practical)	Assisting in carrying out activities of daily living (ADL)	Diploma, bachelor's degree, or other similar trainings in nursing
Physiotherapists	Diagnosis of physical rehabilitation needs and management of rehabilitation conditions	Diploma or bachelor's degree in physiotherapy/orthotics/prosthetics

<sup>16</sup> Personal care workers/assistants are referred differently across countries. For instance, they are termed 'certified care workers' in Japan, 'care helpers' in South Korea, 'healthcare assistants' in Singapore, and 'paid caregivers' in Thailand, to name a few. Perceptions of their role, and the level of training required, can make it more difficult to harmonize skills and qualifications across countries.

Role	Key Tasks	Minimum Qualifications and Training Required to Practice (Generalized)
Speech therapists	Diagnosis and management of speech disorders	Degree in speech and hearing science
Medical doctors	Diagnosis and management of medical conditions	Full time medical degree including clinical training; postgraduate diploma; geriatric medicine; other certifications and training programs
Geriatricians	Diagnosis and management of medical conditions specializing in LTC	Full time medical degree including clinical training; postgraduate diploma; geriatric medicine; other certifications and training programs
<b>Informal</b>		
Family, friends, neighbors	Informal care and/or primary caregivers	None, often voluntary
Volunteers (e.g. village health worker, home care, caregiver)	Some health and social care	Limited training

*Source:* Own based on Loichinger and Pothisiri (2018).

The prevalence of on-the-job training and up-skilling also differs. Very few countries have developed a career structure for LTC workers, giving them the ability to up-skill and move into more complex and demanding roles (here, Japan is an exception, see Figure 9). As a result, the OECD estimates that over 63 percent of LTC workers globally are not adequately trained to provide the necessary help (OECD, 2020a). Skill deficiencies include insufficient geriatric knowledge; understanding of safety procedures; caring needs after hospital discharge; stress management skills; and soft skills. Further, while Table 1 shows a relatively clear division of labor between job roles, the OECD (2020a: chapter 3) writes that LTC jobs are more “complex than often portrayed,” with LTC workers’ tasks going beyond their core job descriptions.

The following sections describe the main functions and characteristics of two of the most common and critical types of LTC workers in Asian countries<sup>17</sup>—nurses and personal care workers—with a view to understanding how and whether their expected tasks match their required qualifications.

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<sup>17</sup> Personal care workers form the majority of the LTC workforce in general. For example, in Taiwan, personal care workers account for 66–70 percent of care manpower but are engaged in 80–90 percent of care work (Cheng et al., 2020).

## Nurses

Nurses provide four main functions: health care provision (personal care, cleaning wounds, and bandaging); health care monitoring (of physical status, pain, and discomfort; monitoring conditions, and treatments); care coordination (referrals; development and implementation of care plans); and communication with families (answering queries, providing support). Unlike personal care workers, in most countries, nurses are licensed to administer medication and help implement care plans, closely interacting with both personal care workers as well as medical doctors and others in the health and social care workforce. Increasingly, nurses are expected to focus on new aspects of LTC provision including telemedicine and eHealth and perform preventative actions concerning nutrition and dementia (OECD, 2020a). In Singapore, a shortage of physicians is forcing nurses to pivot towards more complex cases and procedures. Their expanded scope of practice includes, among others, administering of intravenous infections and clerking of patients (Chua, 2020).

Nurses are generally better qualified and have higher education levels than personal care workers. In many countries, individuals face a few different tracks to become a registered nurse, including the obtainment of a Bachelor of Nursing degree, a diploma in nursing, or an accelerated diploma/degree program for mid-career entrants. Alternatively, vocational routes place greater emphasis on technical skills and serve as a pathway for those who do not qualify for enrollment into nursing diploma or degree programs (Chua, 2020). Nurses do not necessarily specialize in geriatric care training as, often, there is no older persons' care training in the general curriculum and no national curriculum for LTC nurses. As such, older persons' care training remains optional and participation rates are low (OECD, 2020a). Further, our countries of origin have their own national training curriculum for nursing (although not LTC nursing), which can differ significantly from that of countries of destination (Koy, 2015).

Nursing shortages are particularly acute among our selected countries of destination, even where foreign recruitment efforts have been in place for decades. In the case of Singapore, for example, nursing shortages are felt most acutely in LTC facilities where care settings are not as popular with nurses due to their perceived lack of reputation, development, and promotion opportunities (Chua, 2020). To partially address this, the government has built more acute and community hospitals, as well as LTC facilities, to increase the demand and competition for nurses and other health professionals.

According to some LTC experts, the shortage of qualified nurses can be attributed to fragmentation across sectors. For example, in Japan, there is a chasm between the social care sector (where LTC workers lie) and the health sector (where nurses lie). Nursing experience is not counted as social care experience, or vice versa, despite the overlap and interconnectedness in tasks (Kyushu University and Yamaguchi University, personal communication December 10, 2021). Relatedly, while there is clearly an overlap between tasks required of a nurse and tasks required of a personal care assistant, nurses working in the LTC sector may be seen as 'overqualified' and discouraged from leaving the health sector.

Should they leave to work in the care sector, they are seen as leaving behind gaps in the health sector, with potentially negative impacts on health systems (IOM, personal communication December 15, 2021).

### **Personal care workers**

Personal care workers activities can cover four main functions: providing assistance with ADL such as getting dressed and feeding; helping with elderly people's IADL such as cooking; communicating with care recipients and their families about their condition; and performing health care monitoring, including reporting concerns about older people's condition and where possible, providing referrals to professional services.

Given their proximity to care recipients, personal care workers also maintain records of their care and changes in conditions or behaviors affecting their health and social lives. Overall, personal care workers require a vast array of soft skills such as comprehension, communication, social, and interpersonal skills. In Taiwan, one author notes core competences include knowledge on health care, care plan formulation, communication skills, cross-professional team care, safety, professional responsibilities, and ethics (Cheng et al., 2020). A survey by the same author of 255 personal care assistants showed care competence was greatest in the domain of recognition of patient rights, followed by health education and literacy, but poorest in the domain of mental and spiritual care (ibid.).

While many countries require initial training for personal care workers, training rules differ according to the LTC setting (home- or institution-based), or job title (nurse aide, social carer). Training is generally not mandatory, especially for home-based workers, as governments have concentrated resources on institution-based workers (OECD, 2020a). This suggests that governments consider place of LTC care, more than type or nature of care, as a key factor for determining training requirements. In turn, this means many migrant domestic workers are likely to be undertaking the tasks of personal care workers without training, nor without the government in the country of destination recognizing their role.

Among our countries of destination, in Japan (see Box 5) and South Korea, there is no minimum education level for personal care workers. In South Korea, a person without any job experience or license can undertake 240 hours of training, involving equal parts classroom learning, practice sessions and on-the-job training, to become a care worker (OECD, 2020a). Courses ranging from 40–50 hours and 120–160 hours are targeted for personal care workers with prior experience and health professionals respectively (ADB, forthcoming). Personal care workers are required to pass a national exam, after which local governments provide licensed personal care worker certifications reflecting the different levels of training (OECD, 2020a). In Taiwan, personal care workers must undertake 90 hours of training on body mechanics, nutrition, anatomy and physiology, cognitive impairments, mental health, infection control, and personal care skills, provided by the Ministry of Health and Welfare (Cheng et al., 2020).



### Box 5. The Japanese qualification framework for LTC workers

In Japan, while there is no minimum education level required to be a personal care worker, a stepped qualification framework associated with level of experience, applies (Figure 9).

The Japanese qualification framework identifies seven skill levels and their descriptions. Level 1, for example, refers to entry level pre-employment training which requires only basic knowledge and skills for residential and community care, rising to level 3 where workers can provide care without direction from others. After level 3, individuals are certified as care workers. Levels 4–6 reflect capacity to manage teams and collaborate with other professionals. While the skill sets and roles for level 7 are under development, this level is intended to overlap, or be equivalent to, a ‘high’ standard in Europe, such that countries may send and receive workers with ease. Individuals are able to move between the levels, as they gain experience and on-the-job training.

Figure 9. Japanese qualifications framework for LTC



Source: Kyushu University and Yamaguchi University, personal communication December 10, 2021.

Most migrant care workers in Japan come from countries of origin such as Vietnam, Indonesia, and the Philippines. Care work training in those countries typically will only bring a prospective migrant up to level 2 or 3, which is below the level required for someone to become qualified as a certified care worker in Japan. As a result, the Japanese government is investing in LTC training facilities in these countries to ensure graduates leave with a higher level of skills, enabling them to more easily enter the Japanese labor market. They are also exploring ways to support countries of origin in establishing reintegration programs, investing in returnees to start their own community-based care providers (Kyushu University and Yamaguchi University, personal communication January 20, 2022).

While training and education are seemingly good predictors for quality of care, studies show they may not be primary determinants. Instead, LTC institutional culture and feedback to personal care assistants are critical determinants of work performance (Bowers et al., 2000). In the context of ‘aging in place’ this may serve to be a challenge, as formal feedback mechanisms and institutional experience may be in short supply. Training suitable to LTC demand at the community level will need to be prioritized to ensure sufficient quality of care.

The discussion to this point has largely focused on the skills and qualifications required for nurses and personal care workers *within* Asian countries. Certainly, countries maintain their own frameworks to govern the requirements of LTC workers. Yet the extent to which skills, experience, and qualifications are relevant *across* Asian countries is, to date, limited. In an effort to harmonize and mutually recognize qualifications across some sectors, ASEAN member countries have created the ‘ASEAN Qualifications Reference Framework’ (AQRF). However, the framework does not yet fully apply to LTC and does not have a grading system to assess LTC worker competencies (ERIA, 2021). As a result, for example, while being robust in and of itself, the Japanese qualification framework is not easily translated or accepted in other countries like South Korea, as policymakers are unable to agree on the required skillsets and job roles at each level (Kyushu University and Yamaguchi University, personal communication December 10, 2021). However, as one of the leading countries that provide health and LTC workers, the Philippines has developed a training and education system and has recently launched a qualifications framework that is consistent with, and complies with, the AQRF (ERIA, 2021). This reflects the advocacy of the vocational and training agency, which recognizes the importance of ensuring smooth cross-border circulation of human resources for LTC without skill mismatch.

Overall, the Philippines is an outlier in starting to create a mutually recognized qualifications framework. To date, therefore, it is difficult for individuals to transfer skills to new environments, something that will be explored further in the below section on the migration of LTC workers.

## **There is a shortage of LTC workers in Asia**

Regardless of the classification, it is generally considered that there is a global shortage of LTC workers. Ideally, there should be approximately 4.2 formal LTC workers per 100 individuals aged 65 or over (Scheil-Adlung, 2015). In 2014, there was a shortage of 13.6 million LTC formal workers to meet this threshold (ibid.).<sup>18</sup> The highest deficit, 8.2 million people, is in Asia and the Pacific, reflecting the rapidity with which the region is aging. As a result, roughly 65 percent of older people in Asia and the Pacific faced an unmet care need due to staff shortages. In Japan, it is estimated there are fewer than four LTC workers per 100 individuals aged 65 or over, while South Korea has fewer than two and China has 1.1 (ibid.; Table 2). As a result, much of the LTC in these countries is

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<sup>18</sup>The figure is thought to refer to workers who hold professional qualifications regardless of place of employment.

unpaid and provided by family members, reducing their broader labor market participation (ILO and OECD, 2019; Kumar et al., 2022). This informal provision may be one reason why 40 percent of our survey respondents felt their country did *not* face supply constraints in the domestic workforce for LTC.

**Table 2. Coverage gap in LTC supply for available countries**

Country	Formal LTC Workers (FTE) Per 100 Persons Aged 65+	Coverage Gap: Percent of Population 65+ Not Covered Due to Insufficient Numbers of Formal LTC Workers	Number of Formal LTC Workers Needed to Fill the Gap
China	1.1–1.2	72.3	3,615,184
Japan	4.0 (1.3 home-based; 2.7 institution-based)	3.6	91,648
South Korea	1.9 (1 home-based; 1 institution-based)	54.2	Unknown
Thailand	0.7	83.9	226,412

*Sources:* Scheil-Adlung (2015); data from ILO (2015a) based on OECD (2014) estimates.

*Notes:* Relative threshold for ‘insufficient numbers of formal LTC workers’ is 4.2 FTE workers per 100 persons aged 65 or older, deriving from the population-weighted median value of formal LTC workers (FTE) per 100 persons that are 65 or older in a group of 18 selected countries in the Americas, Asia and the Pacific, and Europe.

Such supply deficiencies are exacerbated by the poor working conditions of LTC workers, including low pay. In South Korea, a country with LTC insurance, a survey of 1.2 million LTC workers found their wage levels are less than 50 percent of average wage in all industries (1.32 million won per month, compared to 2.9 million won per month, approximately US\$1,100 and US\$2,400 respectively) (Kim et al., 2020). In China, one study in 2016 of 460 public and private facilities finds the weighted average of after-tax wages of LTC workers was less than 3,000 Yuan per month (US\$480), equivalent to about half of Beijing’s average after-tax wage (Dong et al., 2021). Our survey respondent from Indonesia felt that this lack of a competitive salary, both domestically and compared with other countries, was a major constraint on the supply of LTC workers. Such patterns and trends in salaries, coupled with the supply gap for LTC workers (Inamori, 2017), has led to calls from the ILO to urgently address deficiencies in care work and ensure high quality, decent work in the sector (ILO, 2018).

Despite the impact of COVID-19 on older persons’ mortality in these countries, LTC worker shortages are likely to persist in the coming decades. Evidence suggests that a lack of care workers, both formal and informal, has many negative impacts, including compromising patient care and outcome, and inhibiting the ability of women, who are primary caregivers, from entering the labor force (Van Hooren, 2020). An increasing number of studies are showing caregiving has serious psychological and physical health effects, with caregivers themselves at risk for adverse outcomes (Schulz et al., 2020; Wang and Gonzales, 2019; Loo et al., 2021).

Increasing the number and the quality of LTC workers is therefore a pressing policy challenge for governments throughout the Asian region. To this end, governments have taken initial actions including:

- **Recruitment:** scaling up initiatives to hire from different segments of the population such as students (South Korea);
- **Retention:** postponing retirement ages to keep more people in the workforce, including the LTC workforce and reducing turnover with higher wages, better working conditions and career advancement opportunities (Japan); and
- **Upskilling:** encouraging informal family caregivers to undertake training, and volunteers to become personal care workers (Thailand).

Despite these actions, the supply of workers remains insufficient, and governments are exploring alternative tactics including sourcing labor from abroad. The next section explores this in more detail.

### Section 3. Migrant workers and LTC

#### Key Messages

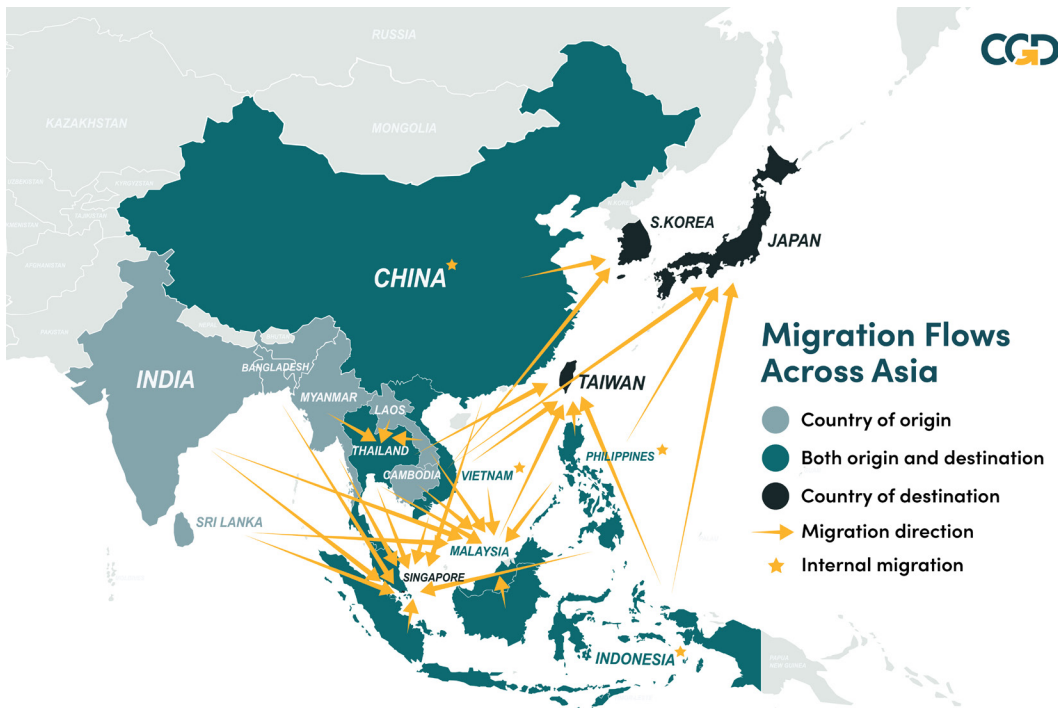
- LTC migration follows existing migration routes in the region, usually from poorer Southeast Asian countries to richer East Asian ones
- Asia relies more on migrant home-based and domestic workers than other regions
- Migration for LTC can have positive impacts (such as remittances and female empowerment) and negative impacts (such as abuse, exploitation, and debt)
- Countries of destination often draw a sharp distinction between ‘low-skill’ domestic workers (who are provided few protections) and ‘high-skill’ registered care workers
- Migration is mainly organized through BLAs or MOUs, which make it difficult to change regulations for the sector as a whole

As is explored above, many countries throughout the Asian region are rapidly aging, increasing the demand for LTC workers in both community-based care and institution-based care settings. Whether due to the wages and working conditions offered, the perception of the sector, or absolute labor scarcity, this demand is not currently being met through local recruitment. As a result, all have turned to labor migration as a way of meeting this demand (Asato, 2021). In this paper, we are primarily focusing on migration from our countries of origin—Indonesia, Malaysia, the Philippines, Sri Lanka, Thailand, and Vietnam—to our countries of destination—China, Japan, Singapore, South Korea, and Taiwan—though we acknowledge more complex flows throughout the region.

## LTC workers' migration patterns

Most labor migration in Asia occurs regionally; in 2013, two thirds of the 10.2 million international migrants in the Asian region came from the region itself (King-Dejardin, 2019). Much of this movement is occurring from poorer Southeast Asian countries to richer East Asian ones (Peng, 2016; 2017), and migration for LTC follows these dynamics (see Figure 10). In general, the main countries of destination for LTC workers are Japan, South Korea, Taiwan, Hong Kong, and Singapore, while the key countries of origin are the Philippines, Indonesia, and Vietnam (ibid.). In this paper, we also explore other increasingly important countries of origin including Thailand and Malaysia. Some of these countries of origin also send workers internationally, particularly to the Gulf Cooperation Council (GCC) countries, as well as the United Kingdom of Great Britain and Northern Ireland (UK), the United States of America (US), and Canada. Some have suggested that 'lower-class' migrant care workers tend to stay within the region, while those that are of 'higher class' tend to migrate internationally (Parreñas, 2020).

Figure 10. Patterns of Asian migration for LTC



While these flows have remained relatively constant over time, the relative importance of specific countries of origin and destination has shifted. For example, until the early 2000s, the Philippines was the largest country of origin for LTC workers to Japan, South Korea, Taiwan, Hong Kong, and Singapore. Since that time, Indonesia and Vietnam have increased in importance (Peng, 2017). In the Indonesian case, Peng (2017) argues this shift is due to the effective marketing of Indonesian care workers as “subservient employees,” as well as their superior language skills and willingness to accept worse labor conditions. For example, in 1982, 96 percent of the foreign domestic workers in Hong Kong were from the Philippines. By 2013, that share had reduced to 50 percent, with Indonesians making up another

47 percent (Ullah, 2015). Though much smaller than Indonesia and the Philippines, since 2000, Vietnam has been steadily increasing the number of its care workers in Taiwan, Japan, and South Korea (Miller, 2015). Similarly, Taiwan has increased the number of workers from Thailand and Malaysia in addition to ongoing recruitment from Indonesia, Vietnam, and the Philippines (Chen, 2013).

China is an interesting outlier. Peng (2017) shows that the country has a huge migrant worker population, but most of its migrants are internal rather than international. Combining local datasets with other information, ILO (2015a) estimated that there were just over nine million domestic workers (or 1.2 percent of total employment) in China in 2010. Given their rapidly aging population in the last decade, it is likely that number has increased, as will their demand for LTC workers.

### **Asia relies more on migrant home-based and domestic workers than other regions**

Quantifying the number of migrant LTC workers operating in the Asian region is very difficult. Data on both migration and care work is limited and non-comparable (King-Dejardin, 2019). Official data sources, such as labor force surveys, usually only record LTC workers operating within the formal care sector. Yet evidence suggests that many high-income countries, including those throughout Asia, also have very large informal or home-based care systems, staffed with even higher proportions of foreign-born workers (OECD, 2015). Peng (2017) argues that the number of migrant LTC workers within Asian countries is integrally linked to both their care work policies and their migration policies. As described above, where formal care services are available, care services and work are more regulated, creating entry barriers for migrant care workers. Where LTC is relegated to the family, the use of migrant workers in the home is extensive. Migrant workers are often excluded from labor protections upholding minimum wages, hours, and standards of work, meaning employers may pay them less and enforce 24-hour contracts (Van Hooren, 2012). Migrants may also be attracted to the in-home sector, especially if it is informal, if they are undocumented or otherwise operating with an irregular immigration status (Van Hooren et al., 2018).

Certainly, the Asian region would appear to rely more on home-based workers than other regions of the world. These home-based LTC workers are a subset of ‘domestic workers,’ people who perform work in, or for, a private household or households (ILO, 2021a). Most domestic workers are women (76.2 percent) and work in informal settings (81.2 percent) (ILO, 2021b). Of the 75.6 million domestic workers worldwide, 50 percent are employed in Asia and the Pacific (ibid.). They earn just 56 percent of the average monthly wages of other employees and are more likely to work either very long or very short hours (ILO, 2021a).

There is a strong crossover between domestic workers and migrants. In 2013, 20.4 percent of the Eastern Asian migrant population and 19 percent of the Southeast Asian and Pacific migrant population were domestic workers (ILO, 2015b). Migrant domestic workers exhibit similar profiles to their national counterparts. Most are women and ‘live-in’ with their employers (ILO, 2016). Some had no experience with care work before they left their countries

of origin, while others were qualified health professionals (e.g., doctors, nurses, therapists, and teachers). This latter process of ‘down-skilling’ has led some commentators to suggest that often migrant care workers are more skilled than their domestic counterparts, but end up being assigned to lower-level tasks and therefore lower rates of pay (Huang et al., 2012).

On average, domestic workers earn 56 percent of the average monthly wages of other employees and are more likely to work either very long or very short hours (ILO, 2021a). Many domestic workers in Asia are recruited through informal agents which are largely unregulated, leading to abuse, exploitation, and debt. Some feel conflicted leaving their families at home, and such movement can have a negative impact on the ‘global care chain,’ as Asis et al. (2004) find in their study of Filipina domestic workers in Singapore. They were also among the groups hit hardest by COVID-19; for example, the number of domestic workers in European countries decreased by 5–20 percent (ILO, 2021b). Many of these people were working informally, with little recourse to income support or other emergency measures. Yet domestic work can also have many positive benefits, especially for the migrant workers who move to take up such roles. Research by Nurchayati (2011) and Ueno (2009) has found that Indonesian and Filipina domestic workers increase their agency through migration, and it could also have some bearing on future fertility choices (Basu and Sundar, 1988).

There are many policies and practices in place to try and improve the wages and working conditions of domestic workers. The *Domestic Workers Convention, 2011* calls on countries to promote and protect decent work and human rights, and the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* pushes for equality of treatment between migrants and nationals. Additional guidelines (such as the ILO’s *Guidelines for Labour Recruiters on Ethical Recruitment, Decent Work, Access to Remedy of Migrant Domestic Workers*), organizations (such as the International Domestic Workers Federation (IDWF)), and projects (such as MIGRANT) continue to push for improvements and national policy changes to better support domestic workers. Some of these policy changes include extending labor protections to migrant domestic workers; ensuring domestic workers have the right to unionize; enshrining a minimum wage and mandatory rest days; and ‘un-tying’ visas (HRW, 2010; Smith and Vukovic, 2019).

Yet many commentators argue that Asian countries have largely let the domestic work market go unregulated, particularly for migrant domestic workers. John (2021) suggests that in most South Asian countries, migrant domestic workers are not seen as ‘workers,’ and are therefore exempt from many labor laws. Governments may regulate the number of migrant domestic workers allowed, but do little to give them access to social services and health care. As Deshingkar and Zeitlyn (2014: 12) argue, the lack of protections, coupled with “negative media portrayals of migrant domestic workers as women with loose morals,” has meant domestic workers are seen as a threat to society with their contributions undervalued.

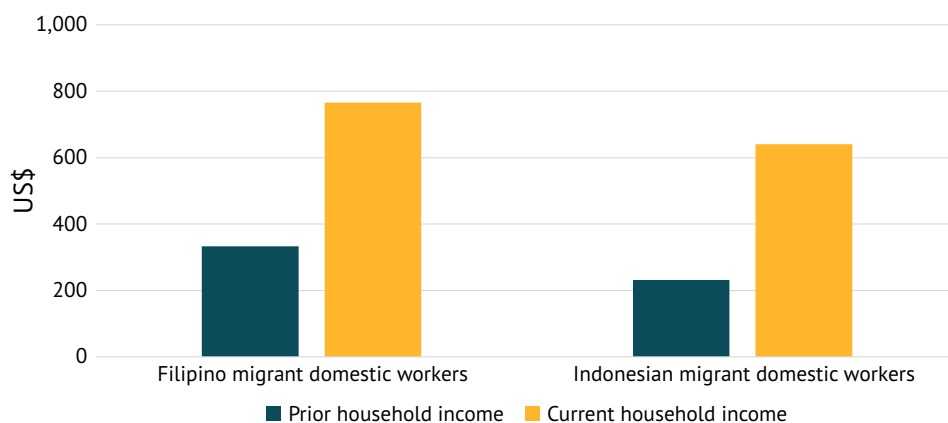
### **Migration for LTC can have positive and negative impacts**

As described above, the high-income countries of the Asian region are struggling to recruit enough local LTC workers, whether for institution-based or home-based care provision.

Employing migrant workers to meet this shortfall can therefore positively impact the country of destination, meeting skill shortages and ‘freeing up’ the time of women in employing households (Budlender, 2011). Both these women, and their migrant employees, will pay higher amounts of tax and spend more money within the economy, thereby benefiting the country of destination. And the migrants themselves likely can access higher wages than they could at home, enabling these workers to send home remittances and save for productive assets. Furthermore, evidence suggests that migration can help elevate a woman’s status in the eyes of her family and community, and contribute to increased decision-making power (Hennebry et al., 2017).

Certainly, these dynamics are all in play throughout the Asian region. For example, Frost & Sullivan (2019) explored the impacts of migrant domestic workers in Hong Kong, Malaysia, and Singapore. They estimated that migrant domestic workers contributed 3.6 percent to Hong Kong’s GDP, 2.4 percent to Singapore’s GDP, and 0.3 percent to Malaysia’s GDP, through direct contributions (e.g. tax) and indirect (e.g. ‘freed-up time’). Despite their poor salaries, migrant domestic workers send home vast amounts in remittances. For example, Filipino migrant domestic workers in Hong Kong, Singapore, and Malaysia sent back US\$1.1 billion in remittances in 2018. The study also surveyed 300 migrant domestic workers in Hong Kong, Malaysia, and Singapore. Of these workers, over three quarters sent money home, with 84 percent going towards household and education expenses. These remittances contributed massively to poverty reduction, with household incomes doubling after four years (Figure 11). These findings are echoed by other studies. For example, Zhou (2017) argues that women migrant domestic workers provide the Philippines with one of its largest sources of foreign currency.

**Figure 11. Monthly household income of Filipino and Indonesian migrant domestic worker respondents before and after migration, 2018**



Source: Frost & Sullivan (2019).

Yet relying on migrants to staff the LTC sector can also have detrimental effects, mainly for the migrant themselves but also for their country of destination. As women move from poorer countries to richer ones, they free up women in those countries of destination to enter the labor market. But this also leaves a gap in care within their countries of origin, taken up by the remaining family and community members. In this way, the so-called ‘global care chain’ can lead to a ‘care drain’ within countries of origin (Hochschild, 2000; Parreñas, 2001; Ehrenreich and Hochschild, 2002; Razavi, 2007; Huang et al., 2012).



It can also have other detrimental impacts on the older and younger family members left behind. For example, in China, higher levels of depression have been found among older parents with migrant children (WHO, 2017). And researchers have found some evidence that the absence of the mother can have a negative impact on children's schooling and education in terms of attendance and drop-out rates throughout Asia (Yi, 2013). Whether this negative impact is balanced out by remittances is unclear. Cortes (2015) finds that Filipino children are more likely to lag behind in school if their mothers migrate than if their fathers migrate, even after controlling for remittances. Their findings are consistent with other studies which show that husbands are less likely to spend remittances on schooling than wives (Antman, 2018).

Many migrant workers within countries of destination are undocumented, or otherwise operating with an irregular migration status. For example, ILO (2016) found that of the 400 migrant domestic workers sampled in Malaysia and Thailand (200 per country), approximately 10 percent of the Malaysian sample and 25 percent of the Thai sample may be undocumented. This is in line with broader research that finds large numbers of undocumented workers throughout the region (Wickramasekera, 2002). This means migrant LTC workers are more likely to work in informal care provision, or in-home, increasing the risk of abuse and exploitative conditions (Box 6).

#### **Box 6. Abuse of migrant workers operating within informal or home-based care provision**

Migrants providing care in informal or home-based settings are particularly vulnerable to exploitation. Such work is seen as low-status, low-paid, and is barely visible. Migrant domestic workers are often excluded from labor laws, meaning they cannot rely on broader social protection systems (Yeoh et al., 2020). They often have their contract terms set by their employers and then live with those employers, which can lead to bullying and abuse (Anjara et al., 2017). For example, a study surveying 215 Filipino, Thai, and Indonesian domestic workers in Hong Kong found that a quarter reported being physically abused and roughly 17 percent suffered from sexual abuse (Ullah, 2015). Another study found that 60 percent of migrant domestic workers in Singapore experienced abuse (Herbe, 2019). Many of these domestic workers argue that, since large portions of their income go home to their country of origin, those countries have a duty to protect them abroad (Branigan, 2014).

There have been many high-profile abuse cases involving migrant domestic workers in Asia over the last few decades, with some leading to shifts in policy. For example, in 2014, a Burmese migrant domestic worker in Singapore broke both legs while escaping from her employer, leading to a ban on Burmese workers going to Singapore (ibid.). Early in 2019, a Filipino domestic worker in Hong Kong was forced to live in a cupboard, given limited food and water, and then fired when she was diagnosed with cancer (Carvalho, 2019). Her experience led to global outrage, and she eventually won a case against her employer in Hong Kong's Labor Tribunal.

These issues were all amplified during the COVID-19 pandemic, which will be explored further below.

Finally, as mentioned in Section 2, wages within the LTC sector are low. While migrant domestic workers are likely to be able to access higher wages abroad than at home, the process of migration itself may envelope a large amount of that gain. The same study of migrant domestic workers in Hong Kong, Malaysia, and Singapore referenced above found that 61 percent of survey respondents were in debt to an average of 4.5 times their monthly salaries (Frost & Sullivan, 2019). Many of these migrant workers had used recruitment agencies which often charge very high placement fees, disproportionate to the salaries the migrants will earn (ILO, 2016). Some countries, such as the Philippines, have abolished recruitment fees (Draper, 2014). Yet the practice is still common in their large migrant recruitment agency market which includes 800 government-certified migrant recruitment agencies (Parreñas, 2020) and countless others that are unregulated.

Whether or not migration for LTC has a positive impact on the migrant and their families depends, to a large extent, on how well they integrate into their country of destination, such as their inclusion within the health and social security systems. Despite our countries of destination having comprehensive health systems, migrants often face stigmatization, language, and financial barriers to accessing services (Loganathan et al., 2020). If migrants can access care, they often incur catastrophic health expenditures (Guinto et al., 2015). Such circumstances are closely linked to the inability of migrants to be fully included in social security systems. For example, 61.5 percent of Asia's domestic workers are excluded from labor laws (Alegado, 2021). Home-based care workers are not mentioned in Malaysia's new Private Aged Care Facilities Act and are excluded from rights and benefits under the 1955 Employment Act (ILO, 2020d; Hasmuk et al., 2020). Our survey respondent from Taiwan noted the exclusion of domestic workers from the Labor Standards Act as one of the biggest impediments to improvements in wages and working conditions. However, there are some notable exceptions (Alegado, 2021). For example, Sri Lankans working in South Korea are eligible for some social security benefits through the Overseas Workers Welfare Fund (OWWF). Governments of countries of origin are also increasingly taking measures to ensure their citizens are ensured health and social security benefits while abroad. For example, the Filipino Migrant Workers and Overseas Filipinos Act (1995) requires overseas employers to provide the same health insurance benefits to Filipino migrant workers as provided for local employees.

### **Many Asian countries have created specific immigration pathways to attract LTC workers**

In most high-income countries, LTC work is deemed 'low-skilled.' As a result, there are very few countries that create specific labor immigration channels to attract migrant care workers. Instead, many migrant care workers enter for non-economic reasons—humanitarian, family, or student migration—and end up working in the LTC sector (OECD, 2020a). The Asian region is slightly different, with some countries creating specific immigration policies aimed at attracting LTC workers and domestic workers (Table 3). These immigration policies may take

**Table 3. Immigration policies in Asian countries of destination for LTC**

Country	Immigration Policy for LTC	Restrictions	Effect of Policy	Remaining Shortfalls in Immigration Policy
China	BLA with the Philippines		300,000 Filipino workers, including caregivers and nurses.	Lack of integration and access to services.
Hong Kong	'Foreign Domestic Helper' visa		370,000 migrant domestic workers, mostly from the Philippines and Indonesia, making up a tenth of the Hong Kong working-age population.	Wages and working conditions remain low. Migrants are under pressure to secure new employment if they lose their job, and there is no pathway to citizenship.
Japan	'Certified Care Worker Candidates' under Economic Partnership Agreements with Indonesia, the Philippines, and Vietnam	Quota: 600 per country Need to be a recent graduate/be certified. Enter on a four-year provisional visa.	3,529 had arrived until FY2017, with another 781 planned in FY2018.	The number of foreign applicants has been declining and is not meeting demand. Few people pass the exam. No clear pathway from care worker to registered nurse. Social isolation.
	New 'Care Work Visa,' <i>kaigoryugaku</i>	Need a job offer, to hold the National Care Worker Certification, and to speak the Japanese language. Visa is for five years, allows family reunification. Likely only available to people already in the country.	The number of people enrolling in care work programs has increased, from: from 17 students from five countries in 2014, to 2,395 students from 20 countries in 2020.	It remains to be seen whether this program, as well as the EPA, will meet the sizable demand. Likely will face similar issues with social isolation.
Singapore	'Foreign Maid Scheme' to facilitate hiring of domestic workers	Two-year permit, which is renewable, but there is no pathway to citizenship. Cannot change jobs. Not allowed to marry, get pregnant, or have family members join them.	As of 2020, 261,800 women live as live-in care workers in Singapore.	Permit holders are not allowed to marry Singaporean citizens or permanent residents without the approval of the Singaporean Government, they are not able to get pregnant or deliver a child, no family accompaniment.
	'S Pass' for higher qualified care workers	Can bring families, change employers, get married, get pregnant, and apply for permanent residency.	In 2012, 90 percent of nursing home workforce were migrant workers, mostly from the Philippines, China, India, and Myanmar.	Difficult for many LTC workers to meet salary threshold.

Country	Immigration Policy for LTC	Restrictions	Effect of Policy	Remaining Shortfalls in Immigration Policy
South Korea	H-2 ‘Working Visit Permit’ admits ethnic Koreans (mainly from China)	Applicants must undergo a three-day training course in the Korean language, culture, and law. Permit valid for three years (renewable).	By 2010, more than 330,000 care workers were arriving each year.	The visa is not meeting demand. The government is exploring legalizing the hiring of foreign nationals as domestic workers.
Taiwan	‘Foreign Live-in Caregiver Program’ allows families to recruit from Indonesia, Vietnam, and the Philippines	Visa valid for three-years, and can be renewed three times, though no pathway to permanent residency. Hard to change employers.	As of July 2017, there are 228,376 foreign domestic workers in households and 14,638 in care homes.	Lack of regulation of employers means that wages and working conditions are poor. There remains much demand for additional workers.

*Note:* See text below for citations.

the form of bilateral labor agreements (BLAs) or memoranda of understanding (MOU) with specific countries of origin or be integrated as part of the broader immigration system.<sup>19</sup>

## China

It is extremely difficult to find data on the number of LTC workers in China. ILO (2015a) suggests that there are over 13 million care workers; Glinskaya and Feng (2018) notes there are one million LTC workers. Most are *internal* migrants, coming from rural areas of the country to work in the cities (ILO, 2015c). For example, in Shanghai, the number of migrant care workers increased from 300,000 in 2009 to 490,000 in 2013 (Peng and Yeandle, 2017). Most are women with low levels of education and training. A 2012 study conducted by the Ministry of Civil Affairs looked at 2,158 LTC workers in 15 provinces, finding that 83.5 percent were women, 79 percent were older than 40, and 40 percent had less than two years’ experience (Glinskaya and Feng, 2018).

There remains a large dearth in the number of LTC workers. The policy response has largely been to focus on developing local training opportunities and encouraging ‘smart’ care services (e.g., turning to automation). On the former, for example, the Ministry of Civil Affairs aimed to have in place six million nursing caregivers by the end of 2020, despite there only being 30,000 in 2010 (Han et al., 2020). However, as a result of low wages,

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<sup>19</sup> Bilateral labor agreements (BLAs) lay out the specific responsibilities of the parties to the agreement and confer binding rights and obligations. By contrast, memoranda of understanding (MOU) lay out generic principles and broad concepts and are usually non-binding. BLAs are more popular in Africa, Europe, and the Americas, while MOUs are more popular in Asian and GCC countries. King-Dejardin (2019: 120) hypothesizes this may be because “destination countries in the GCC and South-East and East Asia have ready access to a plentiful supply of low-skilled migrant workers from Asian countries. It is thus not imperative to secure this labour supply through a formal agreement.”

little legal protection, benefits, and social security, the social status of the profession (and therefore enrollment) remains low. Very few of these policy responses have focused on supporting rural immigrant populations and expanding international recruitment; China's immigration policy solely focuses on admitting 'high-skilled' immigrants (Østbø Haugen and Speelman, 2022).

The one exception to this is a new BLA, signed between China and the Philippines in 2018. It facilitated the employment of 300,000 Filipino workers, including caregivers and nurses, and allowed local Chinese residents to employ foreign domestic workers (Dacanay, 2018; Hall et al., 2020). Yet Filipino domestic workers in China appear to encounter a range of obstacles, including poor physical and mental health, poor social integration and discrimination, and a lack of access to health services (Hall et al., 2020). Our survey respondent from China noted that there are a number of complaints about migrant care workers in China, including that they cannot speak Chinese and do not have the required skills and knowledge to care for older people. Improving these aspects will be crucial if China wants to become attractive to LTC migrant care workers.

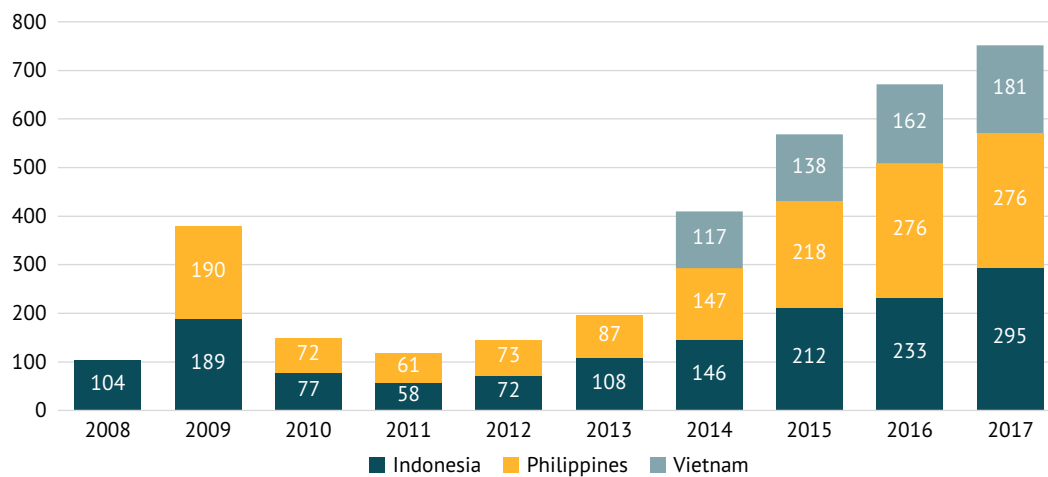
The situation looks different across the water in Hong Kong. Today, Hong Kong has one of the highest densities of migrant domestic workers in the world—370,000 people, most from the Philippines and Indonesia—making up a tenth of the Hong Kong working-age population (Cheung, 2017; Carvalho, 2021). Many of these workers have entered the country through the 'Foreign Domestic Helper' visa. Yet, like other contexts, wages and working conditions remain low, and recruitment agents charge prospective migrants huge fees to move. Some of these agents illegally hold workers' passports (Cheung, 2017). Migrants need to secure a new employer within two weeks of the termination of their last employment, or face expulsion (Parreñas, 2020). There is no pathway to citizenship.

## Japan

Despite its rapidly aging population and projections of severe labor shortages, Japan has been relatively cautious in opening up its care facilities to migrant LTC workers (Ford and Kawashima, 2016). There are two ways in which migrants can operate as LTC workers within Japan: through the 'Certified Care Worker Candidates' stream of their Economic Partnership Agreements (EPA); or through the new 'Care Work Visa.' In 2021, 7.6 percent of all visa holders in Japan were migrant LTC workers (Ito, 2021).

Japan maintains three bilateral EPAs—with Indonesia (JIEPA, signed 2007), the Philippines (JPEPA, signed 2006), and Vietnam (JVEPA, signed 2009)—that regulate trade in services. The EPAs were officially designed to promote bilateral cooperation between the countries, but evidence suggests they were also aimed at increasing the number of migrants in key sectors, especially nurses and care workers. All three place quotas on the number of care professionals who are able to be admitted: 400 nurses and 600 Certified Care Worker Candidates per country (Ohno, 2012). Until FY2017, 3,529 candidates had arrived and 781 were scheduled to arrive in FY2018 (Carlos and Suzuki, 2020). That being said, the number of foreign applicants is neither meeting the quota nor demand (Figure 12; *ibid.*).

**Figure 12. Arrivals of Certified Care Worker Candidates (FY2008–2017, per country)**



*Source:* Carlos and Suzuki (2020).

Certified Care Worker Candidates enter Japan on a four-year provisional visa—during which time they work in a LTC facility earning approximately ¥140,000 (US\$1,200) per month—before they sit their national occupational licensing examination. Pass rates for this examination are very low, just 11 percent in 2012 (Ohno, 2012; Noguchi and Takahashi, 2012). In an effort to keep more workers in the country, Japan allowed those who failed the examination to stay in Japan on a short-term visa and re-sit the examination. Still pass rates are low, mainly due to the language requirement. For example, 55 percent of Indonesian candidates passed the caregiver test in 2015 (Lan, 2018). Those who pass will one day be able to access permanent residency.

Once qualified, migrant workers are only able to work in public and private institutions, rather than providing domestic or home-based support (Lan, 2018; Świtek, 2016). They are matched with hospitals and care institutions by the Japan International Corporation of Welfare Services (JICWELS), under the Ministry of Health, Labor and Welfare (MHLW). JICWELS also oversees the training and examination procedures that EPA candidates must undergo. This process seems to be largely successful. A survey of 53 Japanese care facilities in 2012 found that nearly 80 percent were satisfied with the performance of their EPA candidates (Ogawa, 2012).

Yet many EPA workers end up leaving Japan for two reasons. The first is because there is no clear career pathway from care worker to registered nurse (Carlos and Suzuki, 2020). Indeed, Tabuchi (2011) states that “the [full nursing] exam is to make sure the foreigners will fail;” just four percent of EPA candidates passed the nursing exam in 2011, compared to 90 percent of Japanese candidates (Lan, 2018). The second is the feelings of social isolation and lack of integration within Japan. Świtek (2016: 81) states that foreign workers are perceived to not be able to care for Japanese people as they do not “share with the elderly in the intimate knowledge of their experience as Japanese.”

In 2017, in a bid to increase the number of migrant LTC workers, Japan developed a new ‘Care Work Visa,’ known as *kaigoryugaku* (Carlos and Suzuki, 2020). It builds on pre-existing routes which allowed students or trainees (such as those in the Technical Intern Training Program (TITP)) to stay in Japan after they graduated if they worked within industries with significant labor shortages (Japan Foundation, n.d.). The visa is open to foreigners who receive an offer from a Japanese residential-care facility for a job which provides full-time support to elderly and disabled residents. Applicants must already hold the National Care Worker Certification and speak the Japanese language to a certain proficiency (Desiderio, 2021). The visa is for five years (though renewals are allowed, therefore providing a pathway to permanent residency and citizenship) and does allow migrants to bring their families (Milly, 2020; Carlos and Suzuki, 2020). Given these requirements, it is most likely only available to students already in the country, rather than people seeking to enter Japan to work as a care worker. Thankfully, the number of migrants studying care work within Japan has increased markedly in recent years. In 2014, there were only 17 students from five countries. By 2020, this number had increased to 2,395 students from 20 countries (López and Ohno, 2021).

## **Singapore**

There are, in effect, two ‘classes’ of migrant LTC workers in Singapore: in-home domestic workers, and more highly qualified care workers who operate in public and private institutions. These classes of workers enter Singapore through different visa routes and have different protections afforded to them.

Firstly, migrant domestic workers. In 1978, in a bid to ensure more women could enter the workforce, the Singaporean Government introduced a ‘Foreign Maid Scheme’ to facilitate the hiring of domestic workers, particularly from Malaysia, Bangladesh, Myanmar, India, Indonesia, Sri Lanka, Thailand, and the Philippines. By 2010, a survey found that 45 percent of families with an older person relied on a migrant domestic worker (King-Dejardin, 2019). As of June 2021, 245,600 migrant women were working as domestic workers in Singapore (MOM, 2021c). Their ‘Migrant Domestic Worker’ permit is valid for an initial period of two years and is renewable, but has no pathway to residency or citizenship and does not allow employees to change jobs (Parreñas, 2020; Huang et al., 2012). They are able to earn higher salaries than regular domestic workers (on average S\$800 per month, versus S\$500 per month) but less than local nurses (King-Dejardin, 2019). Social integration is severely curtailed. Permit holders are not allowed to marry Singaporean citizens or permanent residents without the approval of the Singaporean Government, they are not able to get pregnant or deliver a child, and cannot have their family members join them (ibid.). If they break any of these rules, the employer is meant to notify the Ministry of Manpower (MOM) and terminate their contract (MOM, 2021a). The domestic worker is then subject to deportation and placed on a blacklist, meaning they cannot enter Singapore again (Constable, 2020).

Secondly, higher qualified migrant care workers with an approved degree or professional qualification can access the ‘S Pass.’ The pass was introduced in 2004 in an effort to make the

employment of foreign ‘mid-skill’ workers more flexible within a wide range of professions, including health and care work. S-Pass holders must earn more than S\$2,500 per month and can bring their families if they earn more than S\$5,000 per month (MOM, 2021b; King-Dejardin, 2019). In addition, workers holding an S-Pass can change employers, get married, get pregnant, and can apply for permanent residence. Some foreign nurse S-Pass holders find it difficult to meet the criteria to have their skills recognized, or may be blocked from doing so by their employer (Huang et al., 2012). Hence, some (at least 250 according to Seow (2015)), choose to work as foreign domestic workers instead. The salary requirement imposed by the S-Pass means it is likely that only LTC workers in the private sector would qualify (Ye, 2021). Within nursing homes, in 2012, almost 90 percent of the care workforce was made up of migrant workers, mostly from the Philippines, China, India, and Myanmar (Huang et al., 2012).

### **South Korea**

South Korea maintains one of the largest ‘low-skilled’ migration programs in the world—the Electronic Permit System (EPS)—which admits people from countries with which South Korea has a BLA (Cho et al., 2018). However, the EPS is limited to a few sectors where there are large labor shortages and, currently, care does not fall within its purview. There is some suggestion that shortages in South Korea are not yet acute enough to warrant this; there is local demand for such jobs, despite low pay and difficult work conditions, particularly from women who seek roles which do not require long periods of formal training (Seoul National University, personal communication January 8, 2022).

Instead, South Korea admits LTC migrants under its H-2 visa program, also known as the ‘Working Visit Permit.’ The H-2 visa allows migrants to work across 36 ‘low-skilled’ sectors in any type of employment, but is only open to people who are ethnically Korean (‘co-ethnic migrants’) from China or the former Soviet Union countries (Chien, 2019; Um and Lightman, 2011). By 2010, 330,000 LTC workers were obtaining an H-2 visa each year, more than three times the number in 2007 (Chien, 2019). They must undergo a three-day training course in the Korean language, culture, and law, and then receive a temporary permit that can be renewed every three years (Desiderio, 2021). Employees are allowed to change jobs and employers without government approval.

The H-2 visa was introduced in 2008 alongside the establishment of Korea’s Long-Term-Care Insurance (LTCI) system. The vast majority of older people employ migrant workers through this public LTCI system, or through recruiting in-home support (Peng, 2017). Yet evidence suggests that 97 percent of migrant LTC workers choose to operate within the informal, home-based, market, rather than the public LTCI system. Desiderio (2021: 37) argues that this has “created a dual market for dependency support: a formal yet insufficient LTCI services provision market, with the predominant employment of Korean nationals, and an informal market for complementary support to both care institutions and families, which largely employs ethnic Korean women admitted on the H-2 permit.”



The reason for this seems to largely come down to wages and housing. Firstly, while care jobs through the LTCI system provide labor protections and decent wages, migrants in the informal care market can earn more. This is because they can work longer hours, often as 24-hour 'live-in' workers (Chien, 2019). Secondly, obtaining housing in South Korea requires a security deposit known as 'key money' that many migrant workers aren't able to afford (ibid.). Because informal care work is often in-home, care workers are provided with free accommodation. Yet they also often do not have legal employment contracts, leading to delays in payment and not being covered for workplace injuries, and are excluded from migrant worker organizations and unions (ibid.)

This system is not keeping pace with demand. Between February 2020 and January 2021, job ads for domestic workers increased by 322.4 percent. The scarcity is driving up wages, yet there still seems to be little supply. "Korean people in their 30s to 40s tend to be reluctant to work as domestic workers, while the prolonged pandemic has significantly reduced the number of ethnic Koreans arriving from China" (Ji-hye, 2021). This is despite moves by the South Korean government to make it easier for locals to work in the sector: lowering the requirements to take the qualification exam and eliminating prerequisites (Chien, 2019).

## **Taiwan**

In 1992, Taiwan introduced the 'Foreign Live-in Caregiver Program,' or the 'migrant-in-the-family' model to allow families to recruit and hire caregivers, mainly from Indonesia, Vietnam, and the Philippines. Care institutions can also apply for live-in caregivers, but the total number of migrant workers must not exceed the number of Taiwanese workers (Chien, 2019; Table 4). Migrants entering under the program can obtain a three-year visa which can be renewed, though they do not have any pathway to permanent residency (Yeh, 2020). Changing jobs requires the agreement of both the old and new employers (Chien, 2019; Parreñas, 2020).

Those who operate within care institutions have legal protection, with stipulated minimum wages, work hours, weekly days off, and health insurance (Chien, 2019). Yet those who are employed directly by families are not covered under Taiwan's Labour Standard Law because domestic work is not considered a formal occupation. While the Ministry of Labour provides recommended guidelines for employers who hire foreign workers (such as work permit periods, wage conditions, and approved recruitment agencies), many do not follow these regulations. More recently, legislators have been campaigning for families to use migrant workers and urging the Ministry of Labor and Immigration to make migrants more integral to the labor force, while advocating that families who employ migrant workers should also be able to use government services such as respite services (Hsiao, 2021). Our survey respondent from Taiwan noted that there are some government proposals to include some migrant workers within the broader LTC system, though it would only apply to people who meet a high threshold in terms of pay and skills.

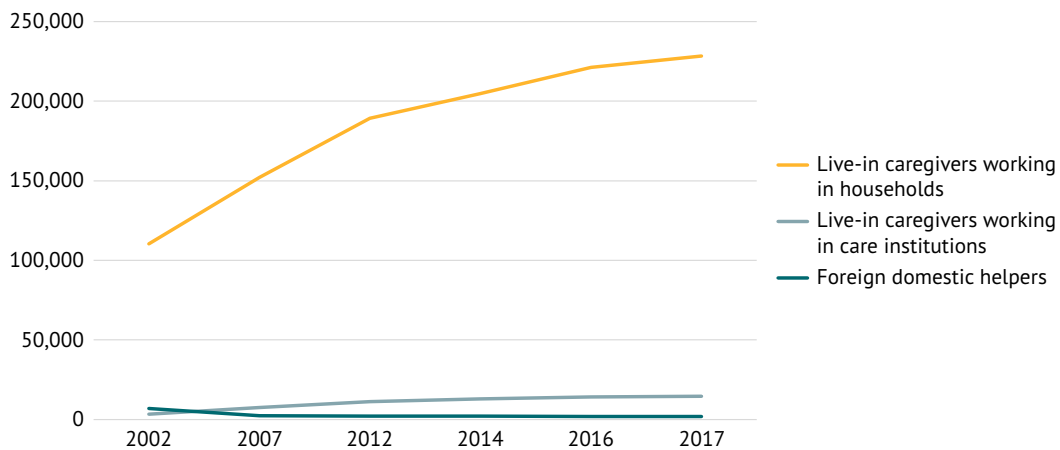
**Table 4. Migrant care workers in Taiwan**

	Foreign Domestic Helpers	Live-in Caregivers	
Type of care work	Childcare, domestic chores, and LTC	LTC	
Work location	Households	Households	Care institutions
Covered by Labour Standards Act?	No	No	Yes
Monthly salary (2017)	NTD\$15,840 or NTD\$17,000 if employed after September 2015	NTD\$22,000	
Quota	Yes (2,000)	No	No
Current number (July 2017)	1,968	228,376	14,638

Source: Chien (2019).

This lack of regulation has led to an overreliance on migrant workers within Taiwan’s long-term care sector, with an increasing number being recruited for LTC (Figure 13). As of 2019, over 240,000 registered migrant live-in carers, of which 99 percent are female, lived and worked in Taiwan (Lin, 2010; Yeh, 2020). Chien (2019) estimates that more than 99 percent have been recruited to provide LTC. Families tend to employ migrant domestic workers over locals as they cost less and work longer hours (Song, 2015). There has been much political debate over the wages of migrant care workers in Taiwan. The average wage for a migrant care worker is US\$567 per month, a figure that has remained constant for 22 years despite pressure from countries of origin and despite the minimum wage in Taiwan being US\$734 (Chien, 2019). Yet it has also led to overwork, industrial disputes, and made the quality of care provision difficult to manage (Lin, 2010). While there have been some improvements in recent years, commentators suggest that this system is incompatible with Taiwan’s broader LTC reforms (Yeh, 2020).

**Figure 13. Number of migrant care workers in Taiwan, 2002–2017**



Source: Chien (2019).

## **Both international and regional bodies have attempted to regulate migration for LTC in Asia**

The increasing prevalence of specific migration pathways to attract health workers (including LTC workers), and the general shortage of health workers globally, has led many in the international community to explore how such migration could be regulated and improved.

One angle being tackled is how to ethically and sustainably increase human resources for health and LTC across borders. While the WHO has traditionally focused efforts on ‘higher-skill’ health professionals such as doctors, nurses, and midwives,<sup>20</sup> they are increasingly recognizing the need to focus also on ‘lower-skill’ cadres including LTC workers. The WHO is currently supporting countries to better regulate health worker migration and reduce ‘brain drain,’ particularly from countries that they deem as having a ‘critical shortage’ of health workers (Clemens and Dempster, 2021; WHO, 2020b; 2005; WHO, interview December 16, 2021). Their *Global Code of Practice on the International Recruitment of Health Personnel* argues that migration from these critical shortage countries must take place through a government-to-government agreement (such as a BLA or MOU) to ensure the development benefits of migration are secured (WHO, 2010; see Box 7 for an example). In 2020, the WHO updated their ‘critical shortage’ list—the two Asian countries on the list are Bangladesh and Nepal—making the *Code* less applicable to the countries of interest in this report. That being said, the general principles in the *Code* (and subsequent bilateral recruitment guidelines, currently being developed by the WHO) are good principles to follow within any negotiations over LTC workers.

### **Box 7. The Memorandum of Agreement (MOA) between the Philippines and Bahrain**

The Philippines is one of the only Asian countries actively seeking to conduct bilateral agreements with countries of migrant destination to safeguard the rights of their overseas health workers (Makulec, 2014). The majority of Filipino health workers are employed in the GCC countries, including Saudi Arabia, the United Arab Emirates (UAE), Kuwait, Oman, Qatar, and Bahrain. The recruitment of Filipino health workers for these markets generally occurs outside of formal structures, with few ‘mutual benefits’ for the country of origin (ibid.).

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<sup>20</sup> One such reason for this could be because ‘lower-skill’ cadres such as LTC workers are excluded from standard data gathering tools such as the International Standard Classification of Occupations (ISCO). Yet another reason could be the fact that it has been difficult for the WHO to work with countries to regulate the migration of these ‘high-skill’ professionals, let alone LTC workers.

The agreement with Bahrain, signed in 2007, is the only such agreement in the GCC (POEA, 2007). It has been cited as an example of good practice, using the ILO decent work standards and ethical recruitment principles. Under the agreement, Filipino health workers get the same rights and responsibilities as local workers and bilateral exchanges (scholarships, capacity building, technological, and financial transfers) are secured (King-Dejardin, 2019). The intentions of the agreement, as stated by officials present, is to ensure Bahrain becomes a “medical oasis in the Middle East and Africa” and that the Philippines becomes a “center for excellence for health services, health science education, and health research” (GMA, 2007). As of 2019, there were 18,663 Filipino domestic workers in Bahrain (Ramos, 2020).

Another angle of focus is on how to improve the wages and working conditions of migrant LTC workers, something which the International Labor Organization (ILO) has long supported.<sup>21</sup> Instruments, such as the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, signed in 1990, aims to guarantee equality of treatment between migrants and nationals, including wages, working conditions, and rights (United Nations Office of the High Commissioner for Human Rights (OHCHR), 2020). Some countries of migrant origin in Asia signed the International Convention, including Bangladesh, Cambodia, Indonesia, and the Philippines, though there was not widespread take-up. Similarly, activism by domestic workers themselves and their organizations led to conventions and recommendations being ratified in recent years. However, many countries are yet to ratify such agreements (ILO, 2021e), with some arguing that they have their own ‘superior’ frameworks (John, 2021).

Complementing the work of the ILO, the International Organization for Migration (IOM) also works to improve and promote LTC migration throughout the region. Certainly, the document they spearheaded—the *Global Compact on Safe, Orderly, and Regular Migration (GCM)*—adopted in 2018, includes a number of objectives which aim to increase legal pathways for migration, improve protections, and provide access to basic services for migrant workers (UN, 2018). All of the countries analyzed in this report ratified the document; indeed, only 17 countries voted against or abstained, none of which were in Asia. The first regional review of GCM implementation in Asia occurred in March 2021. In advance of this, UNESCAP (2020) published a stocktaking report. While it highlighted some good progress since 2018, it also argued the need for more to be done to promote skills training and competency recognition for migrant domestic work, enforce decent work conditions, and ban recruitment fees.

IOM has also worked to improve the recruitment of migrant LTC workers, especially migrant domestic workers. For example, in 2020, IOM released their *Guidelines for Labour Recruiters on Ethical Recruitment, Decent Work, Access to Remedy of Migrant Domestic Workers*. The guidelines were derived from the International Recruitment Integrity System (IRIS) Standard and include principles such as prohibition of recruitment fees, respect for freedom of

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<sup>21</sup> For a full list of care-related international labor standards, please see ILO (2018: 384).

movement, access to remedy, and an overview of fundamental rights at work (IOM, 2020a). IOM has worked with countries throughout Asia to promote ethical hiring practices of migrant domestic workers, including working directly with employers to encourage best practices (IOM, 2020b).

Beyond these international organizations, there have been several efforts at the regional level to better understand and regulate migration for LTC. In 2008, the first meeting of the ‘Committee on the Implementation of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers’ (ACMW) was held, adopting a workplan which (among other things) focused on protecting and promoting the rights of migrant workers. The group has met 13 times since then, now known as the ASEAN Forum on Migrant Labour (AFML), with more recent meetings focusing on labor migration in a post-pandemic future (ILO, 2021c). The AFML is hosted by the current chair of ASEAN, with support from ILO, IOM, UN Women, and the Task Force on ASEAN Migrant Workers. The importance of migration to the economic development of the region is well articulated in the ASEAN Vision 2040, which states that ASEAN “can accomplish an integrated skilled-labour market” through a number of efforts including qualification recognition and preferential employment of ASEAN nationals (ERIA, 2019).

Finally, the Asian Development Bank (ADB) has supported knowledge sharing between countries of origin, destination, and multilateral and specialized institutions on LTC and aging, putting forward policies to fill human resource gaps to meet LTC needs. Through the ‘Working Group on Health Cooperation,’ comprising six Southeast Asian countries and territories including two bordering provinces of China, ADB has supported migrant health projects and technical assistance (ADB, 2021c). A *Health Cooperation Strategy* for 2019–2023 guides policymakers on priority actions to be carried out, including improving health care access for migrants and supporting human resources for health (ADB, 2021d). Simultaneously, in light of COVID-19, ADB has carried out projections on migrant remittances and put forward policies to increase migrant welfare (ADB, 2020b). A priority going forward will be to support governments to provide sufficient health and social protection for their citizens and migrants. ADB is committed to a multi-sectoral approach incorporating health, social development, and education, among others, to achieve such goals.

Overall, therefore, the picture is mixed. Certainly, Asian countries have been quick to work with international bodies such as the WHO, ILO, and IOM to ratify conventions and legal instruments, and seek to incorporate their provisions into their national laws. The rights afforded to migrant LTC workers have improved in recent years thanks, in part, to these international efforts. Yet there still remains a gap between the aspirational objectives laid out in these documents and practices on the ground, especially in implementing guidelines and recommendations. A part of this could be financial limitations, but we acknowledge that it also takes many years of trust building and cooperation for countries to agree on common goals and find mutually agreeable paths forward. With regards to the focus of the report, one of the biggest gaps is guidance to countries of destination and origin with respect to developing ethical and sustainable migration pathways for LTC workers.

## Section 4. The impact of COVID-19 on LTC migration in Asia

### Key Messages

- In Asia, COVID-19 has had a disproportionate impact on older people and migrant LTC workers
- Migrant LTC workers were often excluded from health systems and pandemic recovery plans, with many having their mobility banned
- Some countries put in place supportive policies, enabling migrant LTC workers to more easily move and exercise their rights
- The extent to which these policy responses will remain post COVID-19 is still unclear

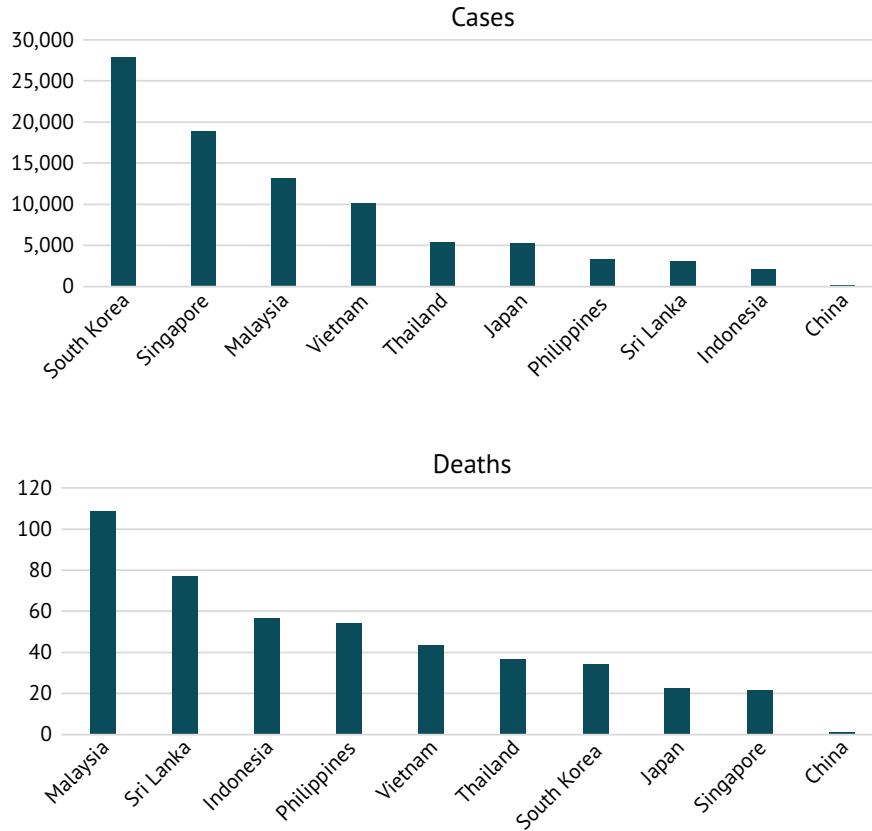
This report has identified multiple challenges to the sustainability of LTC throughout Asia, all of which were problematic prior to the arrival of the COVID-19 pandemic. With COVID-19, many of these challenges have become much more acute. This section gives an overview of the spread of COVID-19 in Asia and its impact on the economy and employment patterns, before moving onto its effects on migrant LTC workers. We present examples of how countries have reacted to COVID-19 by shutting borders and suspending migration, shifting requirements and policies, and opening new pathways for needed workers. It remains to be seen whether these policies will be continued post COVID-19, though this report's recommendations provide examples of policies we believe should be carried forward.

### COVID-19 continues to negatively impact Asian countries

The first reports of COVID-19 arose in Wuhan, China, in early December 2019. Due to China's position in the region, countries throughout Asia were hit particularly early and badly by the spread of the pandemic (OECD, 2020b). Countries have been worse or better off at different points in time, but no country has been spared. For example, while China was heavily impacted in the early days of the pandemic, they were able to contain the virus and eventually became one of the least affected countries in the region (ILO, 2021b). Similarly, Japan and South Korea were largely able to contain the spread of the virus early on due to high levels of adherence to mask wearing and social distancing; strict border and lockdown policies; and recent experience in handling and responding to infectious disease outbreaks. However, all countries continue to suffer from outbreaks and hotspots as the infection has mutated, and multiple waves are still expected in coming months and possibly years.

Among our focus countries, as of early-April 2022, Malaysia has the highest number of deaths and one of the highest case loads per 100,000 population (Figure 14). South Korea, Sri Lanka, Thailand, and the Philippines all feature highly. Singapore is notable for having the second highest number of cases, but one of the lowest death rates. That being said, the Asian region has not been as affected as other regions of the world.

Figure 14. COVID-19 cases and deaths, cumulative total per 100,000 population



Source: WHO Coronavirus (COVID-19) Dashboard, retrieved April 6, 2022, <https://covid19.who.int/table>.  
 Note: The only one of our focus countries not to have disaggregated data is Taiwan.

The COVID-19 pandemic especially affected the health and wellbeing of older people and LTC workers throughout the region. The nature of the virus meant it disproportionately affected older people, with mortality from COVID-19 being 62 times higher for those aged over 65 than those under 54 (Yanez et al., 2020). Those residing in crowded and poorly ventilated care homes suffered particularly badly (UNI Global Union, 2020). Many institutional care settings attempted to limit the spread of the virus by banning visits, isolating affected residents, and heightening cleaning. Some governments prioritized care homes for what was, at the time, precious and scarce resources. For example, South Korea included care homes as a priority for diagnostic testing (OECD, 2020d). WHO guidelines have also urged leaders to prioritize vulnerable groups such as older people and their carers for vaccines in the context of supply shortages (WHO, 2020a).

Yet policies to protect LTC workers have largely been deficient, especially for those working in institutional settings. In early 2020, the ILO (2020c) surveyed 309 ASEAN migrant workers in seven ASEAN countries. They found, among other things, that 33 percent of those surveyed were not provided with personal protective equipment (PPE). Many found it difficult to physically distance within confined spaces in their care homes

(Hasmuk et al., 2020). Care workers may also not have had the health care training or ability to implement infection, prevention, and control protocols (OECD, 2020d). As migrant LTC workers fell sick or were absent, the number of patients per carer increased, thereby increasing spread and pressure on carers. Care workers were also often employed in multiple facilities (UNI Global Union, 2020). For those operating in homes, there was an increase in the amount of cleaning tasks they had to perform as their employers worried about infection, having an impact on health and wellbeing (Lui et al., 2021). They were also more likely to care for those who are ill in the household, without being given adequate PPE (ILO, 2020d).

## **Migrant LTC workers were among the worst hit by COVID-19**

### **Decreased economic opportunity, but steady remittances**

While the introduction of border restrictions and lockdowns was largely able to curb the spread of the virus within Asia, it had a devastating impact on lives and livelihoods within the region. The ILO (2020b) estimates that Eastern Asia, Southeastern Asia and the Pacific, and Southern Asia all lost a vast number of working hours, and therefore full-time jobs, particularly in areas most economically impacted by the pandemic such as manufacturing, construction, logistics, and trade (Table 5).

**Table 5. The economic impact of the COVID-19 pandemic in 2020**

	<b>Working Hours Lost Relative to Q4 2019 (%)</b>	<b>Equivalent Number of Full-Time Jobs Lost (Millions)</b>
Eastern Asia	4.2	35
Southeastern Asia and the Pacific	8.2	24
Southern Asia	12.7	80

*Source:* ILO (2020b).

Domestic workers were more likely than any other profession to have lost their jobs, leading to dramatic reductions in working hours and lower wages (ILO, 2021b). For example, the number of domestic workers in Vietnam decreased by 17 percent between the fourth quarter of 2019 and the second quarter of 2020. The country saw a 24.7 percent reduction in the number of hours worked, more than twice the reduction faced by other employees. One of the reasons for this may be the fact that job losses were higher among those in informal employment, and 81.2 percent of domestic workers work in informal employment (ibid.).

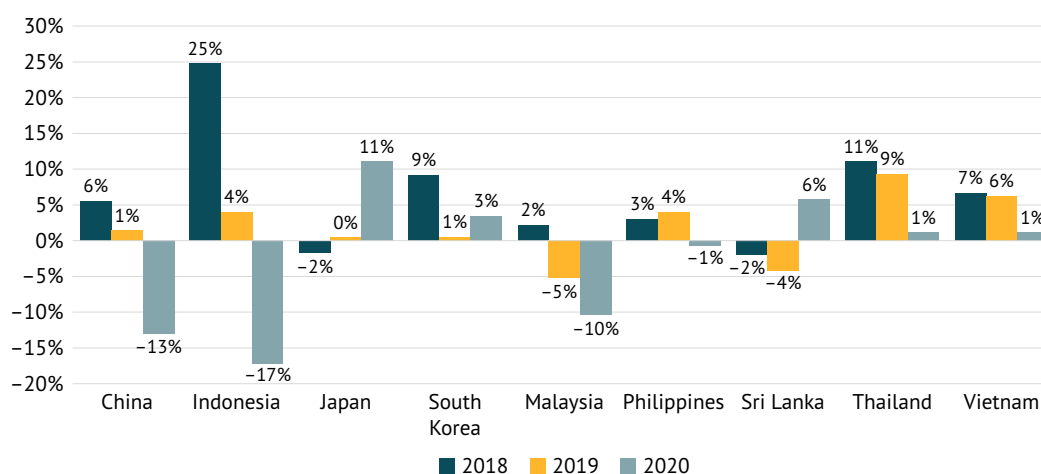
It was difficult for those who lost their jobs to return home due to border closures, or to find new employment, leading many to rely on support from governments and NGOs (ILO, 2020d). For example, the Philippines provided stipends to its migrant workers abroad (ILO, 2020e). Together with Hong Kong, they tried to ensure that workers were able to travel when they had valid employment contracts and were supported by recruitment agencies on both sides. The Fair Employment Agency (FEA) provided advice to migrant domestic workers around COVID-19, contractual matters, quarantines, and avenues for support.



Yet, while this may be the general trend, some groups of LTC workers may have benefitted economically from COVID-19. Many countries, such as the Philippines, saw an increase in LTC employment, creating more opportunities for local and migrant workers alike. Caring for COVID-19 patients commanded higher wages, improving the living situation of these workers and perhaps reducing the imperative for local workers to move abroad. According to one geriatrician and owner of nursing homes in the Philippines, wages of LTC workers working during COVID-19 times may be up to ten times higher than pre-pandemic, both as a result of supply shortages and to reflect the dangerous nature of the work (Private sector, Philippines, interview December 14, 2021).

Lockdowns prevented many migrant workers from physically sending money home, despite money transfer organizations being designated as essential services (ILO, 2020d; UNDP, 2020; Donovan, 2021). Indeed, formal remittance flows to the East Asia and the Pacific region fell by 7.9 percent in 2020, to around US\$136 billion. Yet flows remained remarkably resilient, eventually falling less than they did during the 2009 global financial crisis and falling less than foreign direct investment (FDI) flows to low- and middle-income countries (World Bank, 2021). Flows to South Asia actually *increased* in 2020, by 5.2 percent, to US\$147 billion. This may have been because migrants felt under more pressure to support their families back home (Lui et al., 2021). Within our focus countries, some (such as Japan, South Korea, Sri Lanka, and Vietnam) saw remittances increase while others (such as China, Indonesia, Malaysia, the Philippines, and Thailand) saw remittances decrease (Figure 15).

**Figure 15. Year-on-year changes in remittance inflows, 2018–2020**



Source: World Bank (2017).

Note: No data available for Taiwan and Singapore.

### Restricted freedom of movement

Migrant workers, including LTC workers, were more likely to have their freedom of movement restricted or be forced into unsafe living conditions during COVID-19. In Hong Kong, many employers were unwilling to enable foreign domestic workers to undertake on-arrival quarantine in their own homes, forcing them to stay in temporary

boarding houses. These houses were small and cramped (up to 20 foreign domestic workers could be living in a 400sq ft apartment) which led to several COVID-19 outbreaks (Siu, 2020; Lui et al., 2021). Many were unable to leave and forced to work on their rest day, often because they were seen as potential carriers of disease who would bring COVID-19 back into the house (Lui et al., 2021).

In Taiwan, several allegations of misconduct towards migrant LTC workers have circulated, with accusations of forced quarantining, firm liability if employees contracted the virus, and requirements for migrants to pay for their own COVID-19 care (Jui-ping and Yi-ching, 2021; Turton, 2021; Tzu-ti, 2021a). On June 21, 2021, the Ministry of Labour announced updated guidelines for employers of migrant workers requiring them to implement COVID-19 prevention measures in their workplaces and dormitories (Hsiung-feng et al., 2021), where caregivers and domestic helpers also live. As employers hurried to comply with these regulations, workers—many of whom had complained about their rights being compromised (Tzu-ti, 2021b) as they were placed in quarantine—returned to find their belongings piled up haphazardly in plastic bags on the street as they awaited resettlement to new housing quarters (Everington, 2021a).

Yet it is Singapore that provides the most worrying example. There were reports of Malaysian work permit holders sleeping in train stations as they were unable to head home, yet their employers refused to give them accommodation (Subramaniam, 2020b). The country moved 2,600 care home employees, including migrant LTC workers, into hotels, with the government thanking them for their “big sacrifice, staying away from family, and for putting the well-being and welfare of your residents above them” (Xinghui, 2020). They also forced in-home care workers to stay within their employer’s residence, and effectively locked down those migrant workers living in dormitories. They were threatened with having their work passes revoked if they gathered with other foreign domestic workers (Zhou, 2020). As a result, the highest rates of COVID-19 infections and deaths were among migrant workers living in crowded conditions (see Box 8; ILO, 2021e).

#### **Box 8. The impact of COVID-19 on migrant workers in Singapore**

As with other countries, the Singaporean Government imposed what was known as ‘circuit breaker’ measures to try and curb the spread of the pandemic, including imposing restrictions on movement and forcing people to stay home. This had a severe impact on the country’s migrant domestic workers who were required to stay within their employer’s home. Being always in the presence of their employer, even on their weekly day off, meant there was little time for rest (Antona, 2020). This led to increased abuse and exploitation—a local NGO saw a 25 percent increase in calls from domestic workers during the lockdown—with some attempting to flee (Yang, 2020; The Star, 2020). That being said, Antona (2020) mentions that, in practice, very few of these workers were afforded such freedoms *before* the pandemic, so little changed during COVID-19.

Things were different for other migrant workers throughout the city. In Singapore, thousands of low-wage migrant workers live in vast dormitory accommodation. During COVID-19, Singaporeans were largely free to leave their homes, though migrant workers were confined to their dormitories (aside from being let out to work and run essential errands) (Marsh, 2021). Owing to the often cramped and unsanitary conditions present in the dormitories, cases rapidly began to rise. Ye (2021) argues that the perception of these workers shifted from a “cheapened labour and moral threat, to... a medical threat that need[ed] to be isolated from the rest of society.” The daily count of new COVID-19 cases actually split ‘migrant worker’ cases from ‘community’ cases. As of September 16, 2021, migrant workers accounted for 74 percent of all recorded cases, despite only being five percent of Singapore’s total population (Marsh, 2021).

The extremely strict policy led to isolation and depression with many attempting suicide, leading to widespread outcry (The Economist, 2021b; Marsh, 2021). In contrast to the official policy response, there has been a surge of outreach from community-based help groups in Singapore, providing short-term, direct services, and raising funds. For example, the COVID-19 Migrant Support Coalition (CMSC) aims to meet the physical and mental needs of migrant workers in dormitories (Ray of Hope, 2020). In the last few months, the Singaporean government has trialed a scheme to allow a very small number of migrant workers to make trips to designated areas and has pledged to improve standards in the dormitories, though the future remains uncertain (Reuters, 2021; Agence France-Presse, 2021).

### **Lack of access to health systems**

Many migrant LTC workers, and migrants in general, either do not have access or are concerned about accessing the health systems of their countries of destination (Ginn and Madan Keller, 2020). Indeed, a review of the pandemic influenza plans of 21 Asia Pacific countries in 2016 found that only three (Thailand, Papua New Guinea, and the Maldives) adequately included non-citizens beyond health control measures at borders (Wickramage et al., 2018). Similarly, a 2014 analysis of five ASEAN countries’ health systems—Indonesia, Malaysia, the Philippines, Singapore, and Thailand—found that while all, to some extent, had mechanisms in place to cover migrants, there were substantial implementation challenges in ensuring full inclusion (Guinto et al., 2015).

The pandemic has exacerbated the exclusionary nature of health policies towards migrants (USAID, 2020). Especially in the early days of COVID-19, access to information, testing, and treatment was impeded for migrants, with severe impacts on, and lessons for, countries of destination (ibid.). For example, the initial exclusion of ‘low-skilled’ migrants in Singapore’s response led to a second spike in COVID-19 cases, compelling the government to expand testing (Koh, 2020). Even where countries have made efforts to specifically include migrant workers, such as in the Philippines which offered free testing upon arrival to repatriated migrant workers, limited health system capacity meant delays in diagnosis and undetected cases (Asis, 2020). Now, despite global efforts, migrants are also likely to suffer poor access to vaccines (WHO, 2021c).

Some countries are putting in place measures to better integrate migrant workers into their health and care systems. For example, Singapore has announced new measures to better survey the health of their migrant workers, particularly those in dormitories. Mobile clinics will be set up to provide COVID-19 testing and treatment, as well as other medical procedures and provisions (Y-Axis, 2021). Malaysia offered free COVID-19 testing and treatment to all migrants, regardless of their immigration status (UNICEF, 2021). Thailand has managed to cover the majority of its population, whether migrant or not, with some form of insurance. Almost all its citizens are covered under their Universal Coverage Scheme; formal migrants are enrolled in a social security fund (paid for by their employer) and a complementary migrant health insurance exists (paid for by the enrollee) (Tangcharoensathien et al., 2017). Further, during COVID-19, the government set up hotlines for migrants to access information and treatment. The National Health Security Office (NSCO) credits such measures as key to achieving low COVID-19 cases and death rates (Thammatcharee, 2020).

### **Increased workplace abuses**

Finally, the COVID-19 pandemic has exacerbated employment challenges and workplace abuses for many migrant workers in Asia, including LTC workers. For example, an ILO (2020c) study of migrant workers found that 42 percent of respondents had experienced labor abuses. Domestic workers, in particular, are less likely to be covered by labor law provisions and are therefore at risk of labor contract violations. “For live-in migrant domestic workers, losing their job also means losing their place to live. The onset of travel restrictions has increased financial challenges and uncertainty, with many stranded far from home” (UN Women, 2020). In many countries, violence increased. For example, the Women’s Aid Organization in Malaysia saw a 44 percent spike in inquiries in early 2020 (ILO, 2020d). Three countries in the region—Malaysia, Bangladesh, and China—partnered with the firm ELEVATE to support migrant workers with enquiries related to recruitment, health and safety, economic and social vulnerability, and labor rights (Canon, 2020).

Yet it remains to be seen how far these policies will go, and whether they will be maintained after COVID-19. As shown in Box 9, there is little support among countries of destination for migrant workers, particularly ‘low-skill’ and domestic workers, which will result in an up-hill battle for recognition.

#### **Box 9. Public attitudes towards migrant workers and migrant LTC workers**

Throughout the COVID-19 pandemic, migrant workers were frequently seen as vectors of disease who needed to be ‘contained’ to stop the spread of the virus. In Hong Kong, for example, the government ordered virtually all the city’s 370,000 migrant domestic workers to take COVID-19 tests and vaccines. They were deemed ‘high risk’ despite low infection rates (Wang, 2021). Many countries in the region, including Thailand and Singapore, classified migrant workers as ‘others,’ not counting them in COVID-19 case and death rates. In Malaysia, migrant workers reported experiencing discrimination and were stigmatized for causing the spread of COVID-19 (Subramaniam, 2020a; ILO, 2020d).

This is despite the heroic effort made by all health and care workers to support patients throughout the COVID-19 pandemic. For example, Moon (2020) explores the example of South Korea and their ‘K-quarantine’ model of recovery from COVID-19. She notes that the country has been quick to export their recovery model abroad, pouring huge amounts of money into things such as research and development yet little into employment provisions and insurance. This is despite the fact that “care workers and medical personnel made tremendous sacrifices to take care of elders and patients hit hardest by COVID-19,” underpinning the K-quarantine model.

This reaction is perhaps unsurprising, given the impression held of migrant workers among many countries of destination. In 2019, the ILO conducted a study of just under 5,000 nationals of Japan, Malaysia, Thailand, and Singapore, to understand attitudes towards migrant workers (ILO, 2020a). It found that large numbers of people disagreed that there was a need for ‘low-skilled’ migrant workers in their country (56 percent in Malaysia to 25 percent in Singapore) and many felt they were a drain on the economy (47 percent in Malaysia to 30 percent in Singapore). In Singapore, for example, 60 percent of people felt migrants shouldn’t expect the same pay or benefits as locals for the same job. High percentages also felt crime rates had increased due to migration, and that migrant workers threatened their culture and heritage. There were also some positive findings, however, with majorities supporting freedom from violence for migrant women and improved labor conditions for domestic workers. Majorities in every country “supported recognition of care work as a formal profession.”

## **Countries of destination changed migration patterns and employment conditions**

### **Fewer work permits issued**

The last two years has seen a marked reduction in the number of labor migrants moving throughout the world, largely due to four factors: border restrictions to control the spread of the virus; suspended deployment of migrant workers; business closures leading to reduced demand; and reduced commercial flight schedules (ILO, 2021d). As a result, between March and July 2020, there were two million fewer international migrants compared to the expected estimate (UNDESA, 2020). Migration flows to OECD countries—measured by new permits issued—are estimated to have fallen by 46 percent in the first half of 2020 (OECD, 2020c).

The same dynamics can be seen throughout the Asian region. For example, Japan refused entry to people from 158 countries, including foreign residents who had temporarily left. The number of foreigners entering Japan on work visas between April and August 2020 therefore dropped from 123,000 to 637 (ILO, 2021d). The South Korean EPS has an annual quota of 56,000 people; in 2020, admissions fell short by more than 30,000. Work permits issued in Thailand fell to one-third of their pre-pandemic levels. As countries throughout the region keep their borders and labor markets closed, many are seeing a reduction in foreign entrants, with problematic consequences. For example, Gibbs (2021) reports that 70 percent of the

members of the American Chamber of Commerce Shanghai, China, are having trouble attracting and retaining foreign talent, with more than half reporting pandemic-related travel restrictions are playing a significant factor. ILO (2020d) notes that Malaysia's border closure has resulted in labor shortfalls. One of our survey respondents, from Taiwan, explicitly blamed COVID-19 for the lack of migrant caretakers and the ensuing deficit in LTC supply.

Some countries even issued country of origin and sector specific bans. The extent to which domestic and care work was affected varies. For example, Singapore saw declines in all sectors *but* domestic work and construction. However, Malaysia continued to bar the entry of 'low-skilled' foreign nationals, including domestic workers, for much longer than other professions. This policy caused outrage, with the president of the Malaysian Association of Foreign Maid Agencies, Foo Yong Hooi, commenting that the ban impacted working families with young children and aging parents and may give rise to an increase in families hiring workers illegally (Aiman, 2021).

### **Mixed support for repatriation and return**

Many migrants abroad sought to return to their countries of origin due to a fear of COVID-19, job losses or expected job losses, and the expiration of work permits (ILO, 2021d). An ILO (2020c) study found that 47 percent of migrant workers left their jobs because they had to, and 16 percent had employers who permanently or temporarily ended their contracts prematurely. Yet many migrants remained stranded in their country of destination due to reduced or cancelled flights, a lack of organization on the part of their country of origin, and sometimes restrictions on their mobility. For example, in Thailand, the embassies of Myanmar and Cambodia discouraged migrant workers from returning home after images of crowded bus stations raised fears of infection spread (Subramaniam, 2020b).

Many countries did support their overseas workers with repatriation flights and other forms of assistance. For example, by August 2020, the Philippines had repatriated 147,000 of their migrant workers and received more than 600,000 requests for cash assistance (US\$200, covered by a repatriation fund) (ADB, 2020b). They also offered a hotline for support, temporary shelter, and food. Our survey respondent from Vietnam noted that their Ministry of Labour, War Invalids, and Social Affairs (MOLISA) actively collaborated with other governments in the region such as Japan and South Korea to support 'trapped' migrant workers abroad. Not all countries were as generous. After maintaining monthly repatriation flights through 2020, in May 2021, the Vietnamese embassy in Malaysia decided to stop accepting registrations for repatriation flights, leaving thousands stranded (Nguyen, 2021).

Here, Indonesia provides an interesting example. Early into the pandemic, the Indonesian government's policy was to encourage migrant workers to stay in their country of destination to prevent the spread of the pandemic. For example, in response to 100,000 migrant workers returning to West Java in March 2020, the governor stated: "Mudik [the act of returning to hometowns or villages] is going to worsen our situation. Please stay where you are for the time being" (Chew, 2020). The government had no repatriation plan, instead providing logistical assistance and support to prevent migrant workers from returning. Yet this policy

stance quickly shifted. By August 2020 the country had repatriated 142,809 people, including migrant workers, students, tourists, fishermen, and seafarers (United Nations Office of the High Commissioner for Human Rights (OHCHR), 2020). In addition, Indonesian authorities worked together with the Korean International Cooperation Agency (KOICA) and IOM Indonesia to provide support to returning migrant workers (IOM, 2021a). This cooperation has culminated in a report identifying best practices which could be leveraged into permanent policy, including cooperation between authorities along migration corridors and the involvement of non-government actors (IOM, 2021b).

### **Largely improved visas and employment conditions**

Several countries, wary of the impact of border restrictions and changing employer demand on the rights of their migrant workers, made steps to shift their employment conditions. South Korea granted three-month extensions to those with expiring visas, and Singapore extended expired work visas for two months. Taiwan barred entry to new migrant care workers but implemented successive six-month extensions for existing workers; in March 2021, 3,929 domestic caregivers applied for extensions (Everington, 2021a). Thailand granted permission to migrant workers with expiring permits to stay for an additional two years, impacting about 130,000 people from Myanmar, Cambodia, and Laos (ILO, 2021d). Participants in Japan's TITP, who were unable to continue their program due to COVID-19, were supported by the Immigration Services Agency to re-apply to one of the other 14 sectors under the special skilled visa and stay for an additional year (Immigration Services Agency of Japan, 2020).

Other countries focused on the rights of migrant workers, especially migrant domestic workers, to change employers. For example, Taiwan placed a ban on job transfers for migrant caregivers, though lifted this after a few months provided the worker obtained a negative COVID-19 test (Everington, 2021b). Some countries made it easier for migrant workers, especially migrant domestic workers, to switch employers, in a bid to meet overwhelming demand. For example, prior to May 2020, employers of 'helpers' in Singapore had to facilitate a transition to a new employer or pay for the repatriation of the worker. This made it difficult for employees to change employers, and the threat of repatriation was worrying regarding COVID-19 spread. In a bid to meet demand, Singapore announced that employment agencies would be able to "take over the management of the helper during the transition period," providing them with 14 days to find a new employer (Seow, 2020). Yet some commented that the policy assumed domestic workers wanted to move and didn't want to return home. As Brian Tan, president of the Singapore Accredited Employment Agencies Association mentioned, "if it is a supply issue, then the focus should be on how to find a safe and low risk way to start bringing new domestic workers into Singapore" (ibid.).

Despite these amendments, many domestic workers became undocumented or otherwise over-stayed their work permits. Countries such as Taiwan and Malaysia began to crack down on undocumented workers, forcing returns and reducing rights for those found to be in that position (see Box 10; Lamb, 2021; ILO, 2020d). Other countries explored the opposite, enacting regularization and legalization campaigns, recognizing the impact that undocumented workers could have on labor shortages during the pandemic.

### **Box 10. Crackdowns on undocumented LTC workers in Taiwan**

On February 28, 2020, the Ministry of Labor (MoL) instructed the New Taipei City government to investigate the case of an undocumented Indonesian caregiver who tested positive for COVID-19 (Central News Agency, 2020a). It announced that a search in collaboration with the National Immigration Agency (NIA) would soon open to track down undocumented migrant workers in Taiwan. Initially, they said they would check the documentation of all caregivers accompanying older people to the hospital, but backtracked after the Health Minister objected to the plan.

A coalition of NGOs advocating for migrant worker rights initiated a petition to urge the government not to detain or deport undocumented migrant workers who sought medical treatment during the pandemic, among other requests (Central News Agency, 2020b). The Cross-Border Workforce Management Division under the MoL's Workforce Development Agency responded, saying that for the time being it would not coordinate any large-scale crackdown on undocumented workers.

Instead, a program was launched in March 2020 under which overstayers who turned themselves in received a reduced fine of NT\$2,000 (approximately US\$72) and were not placed under detention or banned from entry (Tzu-ti, 2020a). The program ended on June 30. On July 4, the government announced that it would offer cash awards to those who provided tip-offs about foreigners who overstayed (Everington, 2020). There were an estimated 48,545 undocumented migrant workers in Taiwan as of the end of January 2020, with 290 in detention centers (Tzu-ti, 2020b).

### **Both increased and decreased flows of workers**

COVID-19 also had an impact on the migrant deployment policies that many countries of origin had in place. For example, in March 2020, the Thai Manpower Ministry issued a regulation to temporarily halt the placement of migrant workers in foreign countries due to the COVID-19 pandemic (The Jakarta Post, 2020). The regulation was lifted in late July as a means to “accelerate the recovery of the national economy.” However, the most interesting example comes from the Philippines—the main country of origin of migrant workers, and migrant health care workers, in Asia (Box 11).

Other countries looked to expand the number of migrants working within their LTC sector, responding to the substantial shortages that were highlighted due to the pandemic. For example, in March 2021, the Korean Employment Welfare Pension Institute began exploring whether to legalize the hiring of foreign nationals as domestic workers. The aim is to free up Korean women to enter the labor market and even to raise birth-rates. Results were expected in November 2021, though the implementation of any new law is to happen after new regulations are put in place to help improve working conditions for informal care workers, including guaranteeing paid annual leave, severance pay, and access to insurance (Ji-hye, 2021). And in Japan, the private company Persol Holdings plans to welcome more than 100 nursing care workers post COVID-19 restrictions, and up to 3,000 per year by 2024.



They are currently training workers in the Philippines and will soon do the same for workers in Indonesia and Nepal.

### **Box 11. Trading workers for vaccines: the case of the Philippines**

In April 2020, the Philippine Overseas Employment Agency (POEA) temporarily suspended both the deployment of health care workers abroad and the negotiation of BLAs for government-to-government deployment of health workers with the intent of prioritizing the Philippines' COVID-19 response. As a result, only 47 new hires occurred, compared to 30,600 in April 2019 (ILO, 2021d). However, a public backlash forced the POEA to ease restrictions (Tomacruz, 2020a), and a new resolution allowed those with existing contracts and overseas employment certificates (as of March 8, 2020) to leave the country (Tomacruz, 2020b). The resolution also allowed the resumption of bilateral negotiations (POEA, 2020). While President Duterte approved the new resolution, he appealed to health workers to remain in the country during the outbreak (Tomacruz, 2020c).

As of June 2021, the yearly deployment cap was 6,500 for new hires and the Department of Labor and Employment had asked for another increase to 8,000 (Patinio, 2021a; Aguilar, 2021; Mendoza, 2021). Our survey respondent from the Philippines noted that the deployment cap was met with resistance among health worker groups, with many arguing for more globally competitive pay rather than limits being placed on the number of departures. The POEA has said it will consider the increase once the supply of nurses has expanded following the nursing licensing exam.

In an attempt to abide by the cap, the Department of Labor and Employment (DOLE) said in December 2020 that they would be slowing down the sending of health workers to Europe, particularly the UK and Germany (Patinio, 2020). In February 2021, it was publicized that these countries were negotiating for an exemption from the deployment cap, with the latter hoping to hire 15,000 health workers (Galvez, 2021). The Philippines offered to do so in exchange for 600,000 vaccines (Aspinwall, 2021)—purportedly with the intent of using them to vaccinate the country's 570,000 displaced overseas workers (Jaymalin, 2021)—an offer the UK government publicly denounced and rejected and which the German government did not publicly respond to.

However, in May 2021, DOLE announced that the request for the exemption had been granted following the signing of a new bilateral agreement with Germany (Medenilla, 2021; Hernandez, 2021). The German-Philippine Chamber of Commerce estimated that 2,000 workers were “in the pipeline” and would be ready for deployment if not for the cap (AHK Philippinen, 2021). The Philippine Labor Attaché in Germany also stated in March that nearly 4,000 Filipino nurses were expected to be deployed in Germany in 2021 (Patinio, 2021b). In addition, it was expected that the UK would hire 2,000–3,000 Filipino workers each month. In June 2021, presidential spokesperson Harry Roque stated that health workers under government-to-government labor agreements are exempt from the cap (Aguilar, 2021).

Meanwhile in late July 2021, the government deployed 48 home-based LTC workers to Israel, in line with a BLA signed in 2018 (De Leon, 2021). This is the first in a batch of 377 caregivers who were originally scheduled to be deployed last year but were delayed by the pandemic. The POEA had initially posted 500 vacant positions and planned to hire a thousand more in their second round of recruitment. And early in August, 3,000 overseas foreign workers were flown to Hong Kong following the lifting of its travel ban (Philippine News Agency, 2021). The majority were stranded Filipinos returning to their employers, but some were new hires. The deployment of household service workers (HSWs) to the United Arab Emirates (UAE), suspended since 2014 due to poor working conditions, was also resumed in late March (Patinio, 2021c).

The deployment of Filipino workers has been halted elsewhere. In July, the POEA imposed a total ban on deployment to Myanmar due to the threat of COVID-19 and the probable non-provision of healthcare services to overseas foreign workers given its overburdened health system (Patinio, 2021d). It directed Philippine recruitment agencies to repatriate deployed workers. Philippine Ambassador in Tokyo Jose Laurel V said in June 2021 that while demand for Filipinos as “caregivers or homemakers for their aging population” remains, foreign nationals from the Philippines and 158 other countries are still denied entry due to the pandemic (Rocamora, 2021).

## **Section 5. Recommendations**

This report has sought to outline the vast demand for older persons’ care throughout the Asian region, both now and in the future, and the inadequate supply of both local and migrant workers. While many countries have implemented labor immigration pathways for LTC workers, these pathways are not sufficient in scale, nor in the support they provide migrant workers. The COVID-19 pandemic has highlighted the importance of migrant workers to LTC systems. If Asian countries, particularly countries of destination, are to reduce their ‘unmet need’ for care, expanding immigration for LTC in an ethical, sustainable, and rights-respecting way will be required. These efforts should be undertaken alongside reforms to the LTC system itself, focusing on how the system is financed, structured, and resourced. Finally, the pandemic has highlighted lessons learned for how migrant care workers should be supported, both during and beyond crises, lessons that must be kept in mind throughout any reform efforts.

The final section of this paper outlines recommendations for policymakers in Asian countries of destination and origin within four broad categories: support migrants and their families during crisis; build sustainable LTC systems; focus on human resources for LTC; and develop legal migration pathways for LTC.

## Support migrants and their families during crisis

COVID-19 has exposed the shortcomings of national policies vis-à-vis LTC migrant workers. As the above discussion shows, some governments sought to ensure migrant workers had access to healthcare, social protection, repatriation assistance, and other forms of financial support. Other governments didn't prioritize their migrant workers, or even forbade mobility for fear of spreading the virus. In the future, as governments seek to support their migrant workers during crises, a number of lessons from the COVID-19 pandemic should be learned.

- **Ensure remittances are able to flow.** Remittances are a lifeline for many countries of origin and their citizens, including those throughout Asia. Despite economic hardship, border closures, and mobility restrictions, remittances largely continued to flow during the pandemic, supported by national and international organizations. The lessons learned therein should be replicated in future, especially ensuring money transfer operations are classified as essential services and able to remain open (UNDP, 2020).
- **Provide social protection for migrant workers abroad.** As the above discussion illustrates, governments in countries of origin took a range of different approaches, with some supporting repatriation and return or offering cash support, and others effectively abandoning their overseas workers. The latter is short-sighted. Countries which have amended regulations or provided flexibility to extend national social protection schemes to migrants are more likely to achieve income security for all, reduce poverty and inequality, and reduce social exclusion (ILO, 2021f). All these are critical for economic development as well as controlling the spread of disease. Accordingly, any short-term support provided initially by governments should translate into longer lasting policies that include migrants.
- **Ensure migrants can access health systems.** Especially in a health crisis such as a pandemic, migrants must have equitable access to the health system of their country of destination (including testing, treatment, and vaccines) regardless of immigration status or documents they may possess (Ginn and Madan Keller, 2020). This helps ensure migrants are not afraid of seeking treatment and therefore contains the spread for the good of all.
- **Focus on accommodation.** COVID-19 is more likely to spread in crowded and poorly ventilated conditions. The case of Singapore sadly illustrates how migrants living in such conditions can suffer the most during an outbreak. Countries of destination must ensure that migrants have access to low-cost and sanitary housing, and are not confined to dormitory-style accommodation.
- **Help critical workers deploy their skills.** Many migrant LTC workers were unable to use their skills to support in the response because they were undocumented or otherwise operating with an irregular immigration status. Likewise, many were locked into employment contracts which made it more difficult for them to exercise their rights and support employers elsewhere. Supporting employees to move between employers, and exploring regularization policies, can help these critical workers enable the response.

- **Do more to highlight role of ‘low-skill’ workers.** Unlike in other OECD countries, there were few moves across Asia to highlight the role that migrant LTC workers were playing at the frontlines of the disease (Dempster and Smith, 2020). This has led to little support among the public for the expansion of migrant rights, and will constrain the ability of governments to open up new immigration pathways in future. Highlighting the role of ‘low-skill’ workers, especially during a crisis, can help build this support.

## **Build sustainable LTC systems**

Largely, countries throughout the Asian region have not done enough to recognize the large (and increasing) demand for LTC, and the physical and human infrastructure that will be needed to meet this demand. It will be critical to build sustainable LTC systems: encouraging multisectoral collaboration, making the sector more attractive, and providing robust financing. It will also be important to empower older people and their carers, ensuring they hold sufficient information to make the right choice.

- **Take a systems approach which integrates the strengths of each sector.** LTC is an inter-disciplinary, multi-sectoral, issue which requires collaboration and coordination among different ministries, agencies, and stakeholders. Successfully executing an individual care plan would require, at minimum, health experts to ascertain health needs then provide health care, ongoing education, and training for LTC workers provided by training centers or the like; financing experts to ensure sufficient pay for workers while maintaining low levels of personal expenditure for the user; and immigration experts to create space and the appropriate environment for migrant LTC workers. Coordination bodies which prioritize the needs of older people may help lead on, and develop, such systems.
- **Implement policies which uplift the LTC sector and attract LTC workers.** The current system is rightly perceived as one which offers only low wages and difficult working environments. Japan and South Korea have taken measures to increase wages and benefits, improve working conditions, and raise job profiles, while Singapore has enhanced nursing home quality and concentrated on producing better quality LTC workers (ADB, forthcoming). Yet the sector in all three countries continues to suffer from a poor image. Work is needed to make the sector more appealing to both practitioners and policymakers, beginning by implementing policies which bring the sector into better light.
- **Develop robust insurance or financing mechanisms.** Not all countries studied in this report have a robust financing mechanism to prevent catastrophic out of pocket payment for LTC. Yet, where robust financing is in place, such payments appear relatively low and manageable. Very few mechanisms provide financing for hiring migrant workers in the household, and where it is provided, may prove insufficient, unsustainable, and disconnected to labor and immigration laws. Supportive financing mechanisms, which explicitly include and pay for migrant LTC workers, may increase the supply of workers and ensure better recognition of their work.

- **Provide more information to choose the appropriate care.** Older people and their caregivers should be provided with more information about the kind of LTC available and their associated costs, such that they are able to choose the appropriate care. This includes disseminating information on health and social care services provided in the community, especially those supporting ‘aging in place.’

### **Focus on human resources for LTC, including migrant workers**

As is described at length in this report, there are (and will continue to be) persistent staff and skill shortages within the LTC sector in Asia. Yet despite this trend, there has been little attention focused on human resources for health in this space, and the role that migration and migrant workers could play in meeting this demand. Countries of destination must therefore put more support and focus on these efforts, supported by international organizations such as the WHO.

- **Collect and analyze data to understand skills shortages, both in quantity and quality, and enhance workforce planning.** There is very little information collected on current and future staff shortages, by location and by skill/qualification level. Despite LTC workers being classified as health workers, their statistics are not collected as part of the WHO’s National Health Workforce Accounts (NHWA). Further, while core LTC workers such as nurses and personal care workers are clearly in high demand, new(er) allied professional roles such as social workers and physiotherapists are increasingly demanded, and their skills and shortages should also be accounted for. If countries of destination are to better manage the supply of workers (including their dispersion, characteristics and skillsets, career aspirations, and potential), this data must be collected, disaggregated, and shared across the region. Without it, it will be difficult to match the required skills for different levels of care work (for example, what kinds of tasks should be assigned to formal versus informal workers, or even within these categories) and optimize the use of limited resources.
- **Recognize the need for more migration to meet demand.** It is unlikely that staff shortages will be able to be met through local recruitment or retainment policies alone. Migrant workers have long supported LTC systems throughout Asia, and will continue to do so, at least until the standard countries of origin demographically age. Restricting migration for LTC will not reduce demand, but it will likely create a larger informal and undocumented sector and heighten vulnerability (Shivakoti et al., 2021). As such, there must be proper management of LTC worker migration which balances the high need for migrant workers and the outcomes of older people and their carers in countries of origin.
- **Take meaningful steps to recognize the qualifications of registered nurses, to prevent down-skilling.** Many LTC workers, especially migrant LTC workers, could be operating at a higher skill level than they currently do. This constrains their ability to economically make a living, while also depriving their country of destination of their skills. Similarly, if registered nurses are working as LTC workers, either because

they are unable to get their documents recognized or because that sector is more attractive, this must be addressed.

- **Provide LTC workers, including migrant LTC workers, with opportunities and training to advance their skills.** As with any profession, appropriate training and continuing education is critical to improving the skills of LTC workers. This will, in turn, increase the chances that they stay in their roles while creating promotion possibilities. To this end, skills within the health and LTC field must be seen on a continuum, and migrant LTC workers must have the opportunity to progress on this continuum. Here, Japan provides an excellent example (Box 5; Figure 9). While ‘low-skill’ carers may be placed at the bottom rung, all LTC workers have access to training opportunities and can therefore progress. There are some signs that the ‘professionalized’ nature of care in Japan is leading some care workers to want similar systems for their own countries of origin (Yūko, 2017). Note that the visa that the migrant enters on must not constrain their progression up this ladder.
- **Promote standardization of qualifications to enhance migration opportunities for LTC workers.** The current system does not allow for standardization of qualifications and experience, such that LTC workers may face constraints when taking attempting to work in new countries of destination. This limits career prospects and the potential for cross-country learning and cooperation. Given that the LTC system is dynamic and circular in nature—with migrants leaving, returning, and seeking opportunities in multiple countries—it would be more efficient if policymakers were able to recognize and mutually agree upon standards. Japan’s qualification framework is one example which is already being followed by a handful of countries and may provide a good starting point.

## **Develop legal migration pathways for LTC**

Despite COVID-19, the projections above show that there will continue to be demand for migrant LTC workers throughout Asia in the decades to come, though the patterns may shift. Countries of destination such as Japan, China, and South Korea are already liberalizing their visa schemes, and others are taking note. Traditional countries of origin such as the Philippines and Thailand are looking to retain their workers, while other countries such as Sri Lanka and Malaysia are looking to fill the gap. How can these countries develop ethical and sustainable legal migration pathways for LTC in the decades to come?

- Countries of destination should **create a multi-year visa for LTC work.** Some countries, such as Japan, have already developed such a visa and it is likely others will follow suit. The visa should not be restricted to a specific employer, but could be restricted to a region of the country or the health sector in general. As migrants have access to training and up-skilling opportunities, they should be able to move up the care continuum and take on higher skilled roles. These visas would ideally provide a pathway to permanent residency and citizenship.
- Countries of origin should **ensure mutual benefit from any legal migration pathways.** Developing new pathways for LTC workers will provide opportunities for young people and provide an economic boon, only if these pathways are

designed and managed properly. Consultation on such pathways should be led by the Ministries of Health in both countries, though in close collaboration with other government departments, with lessons learned from trailblazers in this field such as the Philippines.

- **Ensure such pathways are built with sustainability in mind.** This recommendation speaks to both countries of destination and origin. The former must ensure that migrant workers are not being used to prop up a care system that has not been designed with future demand in mind, and the latter must ensure that their own health and care systems can cope with the export of migrant LTC workers. Agreements must be favorable economically, not just for the individual worker but for the country as a whole.
- **Enter into BLAs and MOUs which safeguard migrant rights.** The ILO has a vast array of guidance in this space, but such BLAs and MOUs should: (1) monitor recruitment agencies; (2) include minimum provisions for contracts, including wages and working conditions; (3) provide migrant workers with the same rights as locals; and (4) ensure migrants have the right to organize and collectively bargain. In addition, the pandemic has shown that such agreements should have ‘escape’ clauses that could be triggered if the situation changes. The WHO, in developing guidance for LTC migration, should support countries of origin and destination in this effort.
- **Ratify the *Domestic Workers Convention* and enact legislation to support domestic workers.** COVID-19 has exposed the vulnerability that many migrant domestic workers operate within, and the lack of support they have in the legal and social protection systems of countries of destination. The *Domestic Workers Convention*, while not a panacea, provides a starting point for such discussions, though their provisions should also be codified in national law.
- **Encourage regional collaboration.** The above discussion has shown that both demographics and COVID-19 have shifted patterns of migration throughout the Asian region and, as such, countries of origin and destination are shifting. It will be imperative for governments, regional bodies such as ASEAN, and international organizations such as the WHO and IOM, to monitor and support countries to act on these dynamics. Perhaps this could be done through a working group that proposes solutions regarding labor standards and migration pathways, and then works with countries of origin and destination to implement them.

## Annex 1. Demographic data

	Country of Destination					Country of Origin					
	Japan	Taiwan	China	South Korea	Singapore	Philippines	Vietnam	Indonesia	Thailand	Sri Lanka	Malaysia
Total fertility rate (TFR)	1.37	1.15	1.69	1.11	1.21	2.58	2.06	2.32	1.53	2.21	2.01
Life expectancy (2020)	84.4	80.2	76.6	82.8	83.4	71.0	75.3	71.4	76.8	76.7	75.9
Old-age dependency ratio (2020)	48.0	22.2	17.0	22.0	18.0	8.6	11.4	9.2	18.4	17.3	10.4
GDP per capita (current international US\$) PPP (2019)	42,338	23,015 (2016)	16,847	42,278	101,937	9,291	8,381	12,313	19,209	13,626	29,564

Sources: Demographic data from UNDESA (2019); figures for GDP per capita in Taiwan for 2016 from ADB (2021a); and all others from World Bank (2019).

## Annex 2. LTC support and financing arrangements in countries of destination

Country (System Created)	Approach	Public Expenditure on LTC (%)	Financing	Administration/ Premium Collection	Coverage	Care Categories	Eligibility	Provision	Application Process
Japan (1997)	Regulated institutional model	2.1	50% taxes + 50% insurance premia	Pension deductions for those aged 65 and above. Payroll tax for 40–64-year-olds  Municipal governments in charge	Up to 90% of costs (10% copayment; 20–30% charged for high income earners)	7 (2 preventive, 5 LTC)	All 65 and above, 40–64-year-olds with old-age illnesses	Institution-, community-, or home-based care  Public and private sector providers	Questionnaire and interview, establishment of a care plan by municipal government



Country (System Created)	Approach	Public Expenditure on LTC (%)	Financing	Administration/ Premium Collection	Coverage	Care Categories	Eligibility	Provision	Application Process
South Korea (2008)	Regulated institutional model	0.7	60% insurance premia, 20% copayments, 20% taxes	Health insurance payroll tax deductions (4.05%)  National Health Insurance Corporation in charge	80–85% of costs; 20% (institutional care) and 15% (home-based care) copayment. Less copayment for low-income individuals.  Means tested subsidies available	6	All above 65 and younger who suffer from old-age illnesses	Institution-, community-, or home-based care. Cash allowance for exceptional cases  Public and private sector providers covered, but majority private sector provision	Questionnaire and interview by National Health Insurance Corporation
Taiwan* (2015)	Regulated institutional model + liberal market	0.2	40% employer, 30% employee, 30% taxes	Payroll tax (1.19%)  Ministry of Interior and Ministry of Health and Welfare (central government) and Department of Social Affairs (local government)	90% of costs to a ceiling (some exclusions apply eg food and dormitory costs); 10% copayment	4	All who need care due to longer term physical or mental health issues	Public and private sector providers  Institution-, community- or home-based care; Cash allowances	Questionnaire by LTC committee

Country (System Created)	Approach	Public Expenditure on LTC (%)	Financing	Administration/ Premium Collection	Coverage	Care Categories	Eligibility	Provision	Application Process
Singapore EldersShield 400**	Liberal market	N/A	Premia based (\$218 for females, \$175 for males). No subsidies	Premia paid using Medisave account Selected insurance providers	\$400 per month, for six years after first claim	Not specified	Ages 40–65; Excludes people with pre-existing disabilities	Public and private sector providers	Disability assessment (fee applies)
Singapore CareShield Life** (2020)	Liberal market	N/A	Premia based: 2/3 of households eligible for subsidies of up to 30%; additional support from government available.  Participation incentive provided	Pre-funded premia, paid during working years until aged 67 or first claim. Premia paid using Medisave account  Central Provident Fund (CPF) Board and Agency for Integrated Care (AIC)	Monthly cash payment (\$600 in 2020) while severely disabled  Cash support for out of pocket expenses	Not specified	Universal: all born after 1980 automatically and mandatorily covered on 1 Oct 2020;  All born pre 1979 optional participation; all born between 1970 and 1979 automatically enrolled from end 2021	Public and private sector providers	Disability assessment (first fee free)
Singapore Elderfundd** (2020)	Liberal market	N/A	Fully subsidized through taxes	Agency for Integrated Care (AIC)	\$250 per month, no cap on payout duration	Not specified	Lower income aged 30+ who are severely disabled and not able to join CareShield life or other disability assistance programs, and/or have low Medisave balances	Public and private sector providers	Disability assessment (fee reimbursed with first payout)

Country (System Created)	Approach	Public Expenditure on LTC (%)	Financing	Administration/ Premium Collection	Coverage	Care Categories	Eligibility	Provision	Application Process
China	Regulated institutional model + liberal market	0.1			No nationwide program, depends on city/province and pilot stage (pilots carried out in Qingdao of Shandong province, Haidan and Shijingshan districts in Beijing, Nanjing, Shanghai, and Jiangsu Province). Local governments apply a strict means-tested eligibility criteria of the ‘Three Nos’ (i.e. no children, no income, and no relatives). For those eligible, LTC costs are significantly reduced or are provided government support for housing and other living needs				

Sources: Adapted from Maggs (2020), Peng and Yeandle (2017), IBM Japan Health Insurance Association (2021), Kim and Kwon (2020), AIC (2020), and Ministry of Health, Singapore (2021).

Notes: \*Taiwan’s most recent system ‘LTC 2.0’ is not yet passed into law. LTC 2.0 will expand the number of services provided, targets especially vulnerable populations, assign care managers to individuals, ensure continuum of care that includes family support services, and is community care centered to support ‘aging in place’ (Yang et al., 2020). \*\*Singapore also has a range of schemes (not LTC insurance) that provide for older people, such as home caregiving grants, disability assistance, longevity insurance etc.

### Annex 3. List of interviewees

	Organization	Date of Interview
1	London School of Economics	November 22, 2021
2	World Health Organization (WHO)	December 16, 2021
3	International Labor Organization (ILO)	December 2, 2021
4	International Organization for Migration (IOM)	December 15, 2021
5	Asian Development Bank (ADB)	November 1, 2021
6	Economic Research Institute for ASEAN and East Asia (ERIA)	December 13, 2021
7	Private sector, Philippines	December 14, 2021
8	Kyushu University and Yamaguchi University	December 10, 2021 and January 21, 2022
9	Seoul National University	January 8, 2022
10	Serve the People Association (SPA), Taiwan	April 2022 (survey response)
11	Chinese Academy of Social Sciences, China	
12	School of Health and Care Professions, University of Portsmouth, United Kingdom (responding for Indonesia)	
13	Department of Health, Philippines	
14	National Economics University (NEU) (responding for Vietnam)	

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