Coping with Rapid Population Ageing in Asia

Discussions on Long-term Care Policy and Cross-border Circulation of Care Workers

Edited by

Osuke Komazawa

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AHWIN

ERIA

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Foreword [ERIA]

Since the the mid-1980s, East Asia including Northeast and Southeast Asia has led the world in aggressively utilising the task-by-task international division of labour and has achieved fast economic growth and rapid poverty alleviation. One of the keys for the success was to effectively utilise a population bonus by creating jobs for relatively poor people through globalising industrialisation. However, the region starts facing a big challenge on how to deal with the coming ageing society. Although the timing of ageing is different across countries, the pace of population ageing for the whole region is the fastest in the world. The region still has huge development gaps between countries and within each country, so that some countries or regions are likely to reach a high proportion of old people even before moving up to a fully developed stage.

While our research organisation, Economic Research Institute for ASEAN and East Asia (ERIA), had initially concentrated on policy studies in economics, the Asia Health and Wellbeing Initiative (AHWIN) launched by the Government of Japan in 2016 provided us with an opportunity to expand our scope of research. AHWIN aims to promote cooperation and dialogue that will contribute to creating vibrant and healthy societies where people can enjoy long and productive lives, particularly in Southeast and East Asia. Our colleague, Dr. Osuke Komazawa, has established our Healthcare Unit with extra funding from the Government of Japan and has started conducting a series of ambitious research projects on healthy ageing, the long-term care system, the cross-border circulation of care workers, and other projects using a multi-disciplinary approach.

This book project was developed from our participation in the fourth World Social Science Forum (WSSF) held in Fukuoka, Japan in September 2018 when our Healthcare Unit celebrated its first anniversary. Professor Yasuhiko Saito of Nihon University, who has been the principal investigator of our flagship project on the longitudinal study of ageing and health as well as one of the local organising committee members of WSSF Fukuoka 2018, kindly helped ERIA organise two sessions, together with Nihon University. It was a great honour for the Forum to have its opening ceremony attended by Their Majesties the Crown Prince and Crown Princess of Japan (the current Their Majesties the Emperor and Empress). Our sessions in WSSF Fukuoka 2018 were on 'the long-term care system in Southeast and East Asian countries' and 'the cross-border circulation of care workers,' which correspond to Parts I and II of this book. The sessions provided precious opportunities to exchange experts' views and upgrade the whole study, particularly from the academic perspective.

This book is a landmark in our healthcare and ageing studies and provides useful references for a wide range of readers, both academic and practitioners, to obtain basic information on the long-term care systems and cross-border care workers in the region. Parts I and II of the book consist of seven and four country chapters, respectively. Although the chapters were written

mainly based on the information available before the COVID-19 pandemic, they are highly relevant to the current situation. This infectious disease disproportionately affects older people and care workers who are in the long-term care system. It is crucial to take this opportunity to strengthen the social protection and welfare system. I hope the book will provide a good starting point for constructing a prosperous and inclusive society.

I would like to thank Professor Saito for his great mentorship and also express my appreciation to other contributors to this volume. I am grateful to my ERIA colleagues Professor Hidetoshi Nishimura for his guidance and to Dr. Komazawa for his leadership.

Professor Fukunari Kimura
Chief Economist, Economic Research Institute for ASEAN and East Asia (ERIA)

Foreword

In October 2018, the International Science Council convened the fourth World Social Science Forum in Fukuoka in partnership with the Science Council of Japan, Kyushu University, Japan Science and Technology Agency, and the Center for Science, Technology and Innovation Policy Studies. With the theme of 'Security and Equality for Sustainable Futures', the programme contemplated the multiple challenges that humankind faces in the 21st century, as well as alternatives to respond to them. Amongst the long list of topics, participants discussed issues such as emerging social needs, the pro and cons of advanced technology, environmental problems, threats to peace, the corrosive effects of growing inequality on societal cohesion, and policy responses to the challenges posed.

The scientific committee responsible for shaping the forum programme saw the expanding demand for long-term care as a pressing issue to be discussed. Taking into account the actual demographic profile of many societies, and global population trends, we recognised as crucial the question of how to provide for the needs of the expanding strata of older adults. In the quest for a sustainable future, the challenge of securing long-term care is a pressing issue on the policy agenda. The considerable increase in life expectancy in recent times has led to diverse policy responses that merit careful examination. Looking at the peculiarities and outcomes of different policies, and comparing them, provide powerful resources to expand our knowledge and improve our practices far beyond specific geographical areas.

It is extremely rewarding for all of us directly involved in developing the programme of the Fukuoka Forum to see that the two outstanding sessions on long-term care have been made available to a larger public in the book edited by Drs. Osuke Komazawa and Yasuhiko Saito. While focusing on the experience of six Asian countries, the book offers valuable information and insights, the relevance of which transcend Asia. Looking at China, Japan, the Republic of Korea, Singapore, Thailand, and Viet Nam, the authors address questions of global relevance. Advances in health and nutrition, declining birth rates, and the massive entrance of women to the labour market combine to pose new demands for policy responses to increased life expectancy across the world.

The diversity of demographic characteristics and policy solutions discussed in the book illustrates the distinctive singularity of nations. Yet, as the chapters indicate, while singular, nations share many commonalities, isomorphic features, and common problems that make up their universal social character. It is precisely this peculiar combination of singularity and commonality that confers great relevance to the discussion of differences and similarities between nations. Comparing structures, institutions, and policies across borders is valuable to further our knowledge and enlighten our practices. Looking at the experiences of six Asian nations, the book offers the reader a valuable opportunity to see universality in the diversity of situations and the responses to it.

In the geographical area the book explores, it is interesting to look at the distinctive characteristics of a social welfare model adopted in Japan in contrast to the family-based schemes traditionally adopted in other Asian countries. That is, while Japan has opted for an insurance-based scheme and careful quality regulation of care services, in other societies such as Singapore and Taiwan, caregivers are hired by individual families at their own expense and discretion, and there are no official prerequisites regulating the workers' performance. These systems deserve consideration for the quality of the services provided on the one hand and for the labour conditions of care workers on the other. The different, while sometimes complementary, outcomes that the market for long-term care work entails for sending and receiving countries also deserves attention.

The relevance of both the differences and commonalities observed across the six cases discussed goes far beyond the Asian context. They resonate, for example, with the experience of many countries in the Global North that import caregivers. The analyses provided also resonate in Latin America, where the acute need for cash in poor areas exports a high contingent of young adults, mostly female, to supply paid domestic and care work to better-off families, both in their own country and abroad. Very often, to undertake national and international migration, the migrants rely on older members of their family to look after the children that they leave behind. This imbalance between sender and receiving groups breeds other social issues and unmatched demands that transcend the remit of this book, but the insights it offers about specific Asian countries are inspiring for anyone concerned with long-term care. It is also worth noting that the policy targets outlined in the concluding chapter, while based upon the arguments presented throughout the book, offer recommendations of universal value to confront issues that are here to stay throughout the world. In short, if the book chapters constitute a significant contribution to the understanding of problems and solutions peculiar to the specific countries under examination, they also offer valuable ideas and arguments not only to other Asian countries but also to the rest of the world. Present and future generations cannot neglect long-term care issues if we are to honour our ethical and pragmatic commitments to justice and sustainability.

Professor Elisa Reis
Professor of Political Sociology at the Federal University of Rio de Janeiro (UFRJ) and
Vice-President of the International Science Council

Preface

It may be a little difficult to imagine the life of octogenarians, nonagenarians or centenarians if you are still young and studying or working, yet most of the readers of this book are very likely to live until such ages. The twenty-first century is known as the age of population ageing following the century of population explosion. In the north and south alike, population ageing is everywhere, and accompanying the increase in the number of older adults in any given population is an increase in the number of older adults with care needs. Even if we expend maximum efforts to promote health and prevent disease, it is not clear that we will be able to reduce the number of older adults with care needs.

We cannot eliminate non-communicable diseases. You may think you will never suffer from non-communicable diseases if you lead a healthy lifestyle by exercise, eat the right foods, etc. Unfortunately, however, such preventive measures offer no guarantees of immunity from such diseases. Most people never notice impending stroke, heart attack, fracture by accident, cancer, and other non-communicable illnesses until the actual time of onset. Frailty and dementia, moreover, are prevalent amongst ageing populations, and individuals with such conditions tend to require long-term care. Once you acquire such a condition and need long-term care, what do you do? If you are wealthy enough to hire caregivers, the solution is simple. However, how many people in the world can do so?

If we look back historically, we can see that the proportion of older adults in the total population used to be small. Back then, in general, older adults were respected and supported by family and community members. We, however, live in a world of population ageing, which mankind has never before experienced. How can we provide enough care to older adults with care needs in societies where more than one-fourth or even one-third of people are aged 65 years or above? In such societies, it is absolutely necessary to establish universal long-term care systems. This book is an edited compilation of the papers presented, and discussions amongst participants, at the two sessions on long-term care at the 4th World Social Science Forum (WSSF) 2018 Fukuoka, which was attended at the opening ceremony by Their Imperial Highnesses the Crown Prince and Princess of Japan. The Economic Research Institute for ASEAN and East Asia (ERIA) and Nihon University (NU) co-hosted these two sessions, titled, 'National policies, systems, and practices of long-term care in Asia' and 'Long-term care workforce in the era of population ageing: Towards sustainable mobility of long-term care workforce'.

The first session had speakers from China, Japan, the Republic of Korea, Singapore, Thailand, and Viet Nam who discussed their national policies on the provision of long-term care. The focus was on 1) Policy responses to increasing long-term care needs that accompany declining birth rates and ageing populations; 2) determinants of policy responses; 3) institutional structures of care-service provision systems, and 4) policy considerations on the strategic use of family-public-market resources.

The second session included speakers from Indonesia, Japan, the Philippines, and Viet Nam who directed attention to the care workforce in the context of cross-border migration. Presentations focused on receiving countries of the care workforce, as well as demand-supply projections and current policies regarding human resources from foreign countries. Speakers from the countries of origin of the cross-border care workforce addressed issues related to overseas deployment policies and discourse, recruitment systems, and future directions. This session was designed to fill the information gap between receiving countries and countries of origin so that sustainable international mobility systems can be established.

ERIA and NU would like to express their full gratitude to all the speakers for their substantial contribution to the WSSF 2018 and for their willingness to contribute their papers to this publication. ERIA and NU would also like to acknowledge the valuable contribution of WSSF 2018 Fukuoka staff and related colleagues. We hope this book will provide a good opportunity not only to learn about long-term care systems and the realities of cross-border movement of the care workforce, but also to facilitate regional and international collaboration with a view to improving and effecting sustainable long-term care systems.

During the course of the editing, we received exceptionally sad news. Prof. Koichi Ogasawara, one of the authors of this book, passed away in December 2018. As we look back on the day when he moderated the first WSSF 2018 session, we find it hard to accept his death. We dedicate this book to him and promise to follow his wish to establish reliable long-term care systems in societies with population ageing. May his soul rest in peace.

Osuke Komazawa and Yasuhiko Saito

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National Policies and System of Long-term Care in Asia

CHAPTER 1

National Policies, Systems, and Practices of Long-term Care in Asia

Koichi Ogasawara and Kota Ogasawara

1. Asia: Global Centre of Ageing

Asia will continue to drive global ageing in the first half of the century. By 2050, the population aged 65+ in Asia (or 60+ in Thailand and Viet Nam) will shoot up to 956 million, about triple the 2015 population. Over 60% of the world's elderly will be in Asia.

The following socio-political pressures highlight the need for policies to improve long-term care:

- Changing society, including family structure: Less family voluntary care and more individualism
- Push for sectoral-mix care: individuals' self-payment, families' material commitments, communities' mutual support and resource development, governmental public support, and creative marketisation
- Setting of policy in the national context: care and social security philosophy, balance between medical response and social care, networking for sectoral mix, basic idea of social commitment to life management for the elderly (support for independent living or national protection)

Ageing in Asia is conspicuous for the following socio-economic constraints:

- How long-term care incidence relates to poverty, segmentation, and social isolation
- How medical care services universalised quality and quantity to cope with long-term care needs
- How current medical services support long-term care services

Policy response to long-term care provision systems is a matter of national strategy: institutionalisation and socio-innovation, with variation in medicalisation, non-insurance medical-social care mix, insured care service provision based on a universal medial insurance system, and independent care service provision by the medical insurance system.

2. Impacts of Ageing in Asia

Ageing in Asia has at least four major global impacts:

1. It is disruptively rapid. On average, the elderly will make up more than 7% of the total population in 22.9 years in Asia, but in 68.8 years in Europe and North America. In Japan and China, the process will take 26 years, and in Viet Nam, Republic of Korea (henceforth, Korea), Singapore, and Thailand, 18–22 years. By contrast, in France it will take 115 years, Sweden 85, Australia 73, the United States 69, and Canada 65.
   The old population in Asia will increase from 331 million in 2015 to 956 million in 2050: 61.3% (1,558 million) of the world's elderly will live in Asia (United Nations, 2017). Japan, Korea, Singapore, China, and Thailand will substantially contribute to this transition.

2. Diversity in ageing by locality is conspicuous mainly because the population is overly concentrated in the main urban areas and suburbs due to industrialisation and the movement of labour into industrial centres. Overly concentrated regions have become the single leading area of the national economy and the engines of cultural creation and societal innovation. Ageing in these areas does not only mean an increasing old population but also elderisation of society.
   The economic and cultural impact of ageing will be much more severe in underpopulated areas, hollowing out communities.

3. Ageing has proceeded in waves. Global ageing started in the 1940s in Europe and North America, where it proceeded slowly. In Asia, the first wave was in Japan, just after post-World War Two, when the economy grew rapidly. The second, swift wave, in 2016–2026, is in Korea, Singapore, China, Thailand, amongst others. The third wave is approaching in Indonesia, Myanmar, Kazakhstan, amongst others. The fourth and subsequent, relatively loose waves will start in Malaysia, Cambodia, the Lao People's Democratic Republic, Mongolia, amongst others, where the average ageing ratio is 5%.
   Japan (in 2000), Singapore (in 2002), and Korea (in 2008) instituted universal long-term care provision systems. China is experimenting in big coastal cities with the employee medical insurance system. Malaysia is universalising long-term care.
   Countries are sharing their experiences in ageing and their ways of dealing with it.

4. As elderly single and couple households increase, care service provision needs to cover not only long-term care but also support for independent living. This is a competitive field of service, where demand can be met by public institutional care and the private sector. Table 1.1 implies high demand for care as well as market opportunities in preventive and daily-life support services, which one estimate puts at JPY496 billion by 2035 in eight Asian countries, including China (JPY292 billion), Japan (JPY105 billion), Korea (JPY36 billion), Singapore (JPY10 billion), and the Philippines (JPY6 billion) (United Nations, 2015).

Table 1.1. Share of Senior Single and Couple Households to Population Aged 60+ (%)

Country	Male	Female
Japan	51.5	46.9
China	39.7	34.1
Viet Nam	29.8	26.8
Indonesia	24.1	24.1
Thailand	21.3	16.8

Sources: Statistics Bureau of Japan (2013); United Nations (2012).

3. Issues in Long-term Care

Ageing in Asia increases the risks of cancer, heart disease, and stroke, which will double from 2005 to 2030 (Mathers and Loncar, 2006). The risks are closely associated with lifestyle, nutrition, mental stress, and social relations. Prevention and intervention are key to decreasing risk.

Community-based systematic supportive intervention is already a major area of formal long-term care provision in some Asian countries. However, enhancing interdisciplinary intervention systems and promoting interdisciplinary human resource development and work methodology is still an immense task.

For cancer, heart disease, and stroke, vertical division of function is needed from the acute stage to discharge, and from rehabilitation to palliative care. For each medical functional stage, horizontal support for long-term care is important for efficient medical division and for effective self-commitment. Systematic co-working between medical and long-term care services is also an immense task in institutionalising long-term care provision.

The rapid increase of dementia is another issue. The dementia population is estimated to increase from 221 million in 2015 to 667.7 million in 2050. The total economic cost of dementia was US$18.5 billion in 2015 (Alzheimer's Disease International, 2014).

Dementia care needs an integrated approach (early detection and response, preventive control, terminal care); interdisciplinary methodology and skills (medical-pharmaceutical, psychological, behavioural, supportive social care); and appropriate socio-ecological environment (mentally adaptive and behaviourally safe daily-life ecology setting). The G8 Dementia Summit in London in 2013 prompted global cooperation and experimentation in countries where dementia care was already integrated. Still, social stigma and a medical-centred approach remain issues, especially in Asia, where work productivity dominates the conception of human capability and

fluid intelligence as a result of rapid economic growth.

Institutionalisation of long-term care in Asia faces dual policy challenges: the need to start up a rational provision system based on existing resources, practices, and national consensus; and the need to catch up with global standards.

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CHAPTER 2

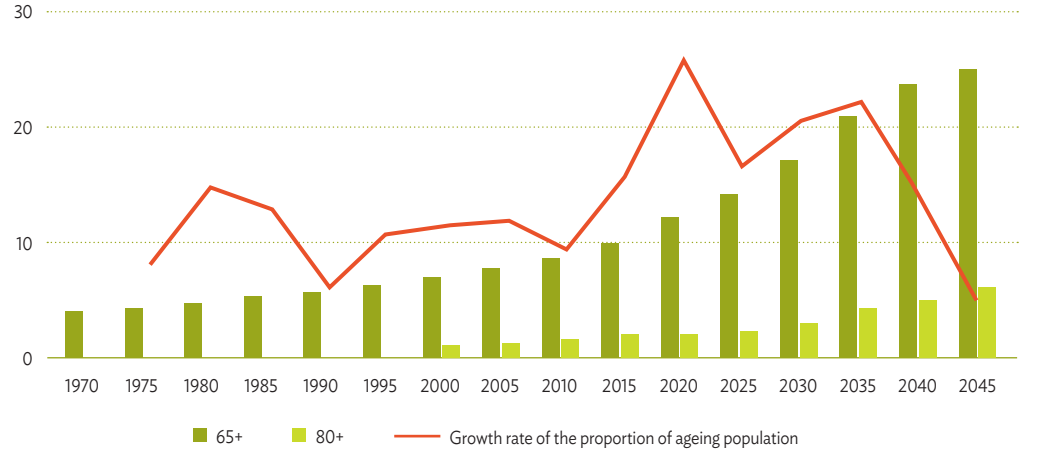
Long-term Care in China: Public Response to the Ageing Society

Yun Zhou and Dandan Pang

1. Background

Due to social development generally and population policies specifically, China is experiencing unprecedented population ageing. In the 1970s, 3.8% of the population was over age 65 but by 2000 that figure reached 7% (Figure 2.1), the threshold of an ageing society. Since then, population has been ageing fast, with changes in the percentage of elderly increasing over the past 5 years. The change in rate was 0.8% in 2000–2005, 1.3% in 2005–2015, and 3.8% projected in 2030–2035. In 2035, the elderly population is estimated to be over 20% of the total population: one in five Chinese will be over 65 years. The growth rate of the proportion of the ageing population increased dramatically in 2010–2015 and will continue to climb over the next 20 years at least (Figure 2.1). China will also encounter ageing of the aged. In 2000, those over 80 years comprised only 1% of the total population; they will make up 4% by 2035. Any small change in percentage or growth rate will result a large population due to the huge base population. Older people (65+) numbered 135.2 million in 2015, will grow to 203.7 million in 2025, and to 299.2 million in 2035 – 68.5 million and 95.5 million increases in 10 years.

Figure 2.1. Population Ageing in China (%)

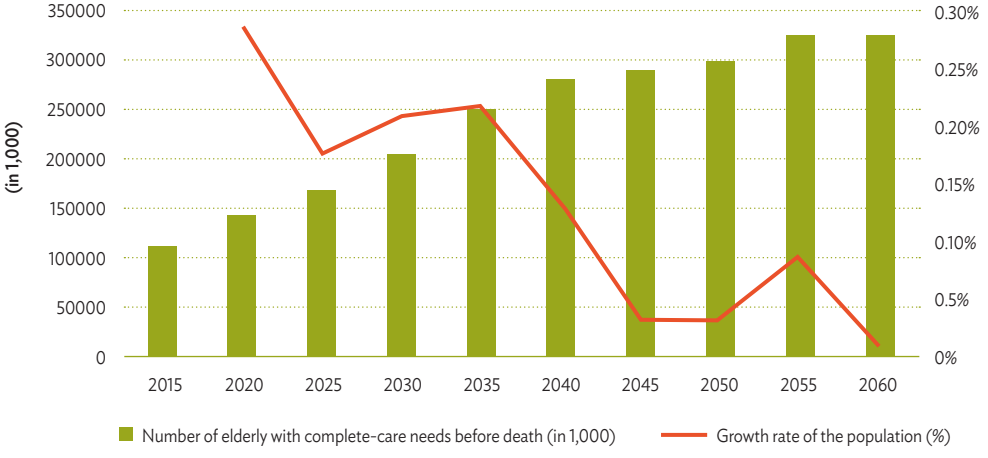


Source: Data of 1970–1985 and since 2000 is from United Nations (2017); 1990–1995 data is from China Population and Employment Statistics Yearbook 2017 (China State Statistical Bureau, Division of Statistics on Population and Employment, 2017)). Growth rates are calculated by the authors.

2. Health Status of the Elderly Population

Long-term care needs to consider the health status of the elderly: the healthier the population, the less worry. A study based on data from the Chinese Longitudinal Healthy Longevity Survey (CLHLS), however, shows that the health status amongst the elderly who had died in 2005–2014 had not been good (Zheng and Zhou, 2019). Not only did 61% of the elderly die with at least one disease but about 33% of the elderly were also unconscious, 72% bedridden, and 83% needed complete care before they died. These numbers imply a heavy care load for families and society. Figure 2.2 shows how serious the situation is, using the percentage of elderly who needed complete care before they died, using data generated from the study and the total elderly population projected by the United Nations (2017). In 2015, 112.20 million elderly were totally dependent on others in their last stage of life (Figure 2.2). The number will increase to 169 million in 10 years and to 248.3 million in another 10 years. The growth rate of this population with special-care needs is expected to increase in 2020–2040, after which it will lose momentum. However, the speed of growth during the first 20 years will lead to a huge and growing demand for care. China is considering ways to manage the problem at the individual as well as policy or societal level.

Figure 2.2. Projected Number of the Elderly Needed Complete Care Before Death



Note: This projection is based on the percentage of the elderly who needed care before they died (Zheng and Zhou, 2019) and the total elderly population projected by the United Nations (United Nations, 2017).

3. Public Responses to Elderly-Care Needs

Individual families are the most important, if not the only, source of care. Most of the elderly live at home. In 2010, China promoted the '9064' model of care: 90% of the elderly live at home with assistance from family members and social services, 6% live at home with help from paid community care services, and 4% live in nursing homes with full services from institutions (China Economic Herald, 2015). Since then, the model has been revised in different regions

but the principle is similar: the family provides most old-age care and the role of society is supplementary.

Public responses are varied, including strengthening institutional reforms, formulating new policies and regulations, and starting trial projects on a long-term care insurance system.

3.1 Government administration reform related to ageing

Two recent institutional changes deserve special attention: the establishment of the Ageing and Health Division (老龄健康司) in the National Health Commission on 10 September 2018, and of the National Medical Security Administration.

The Ageing and Health Division formulates and implements policies and regulations related to ageing, establishes standards and regulations related to medicine and care, and has taken over the role of the China National Commission on Ageing (CNCA, 全国老龄工作委员会)(The Ageing and Health Division, 2018). CNCA was established in October 1999, a coordinating organisation then under the State Council. There are two institutions under the commission: the Office of China National Committee on Ageing (OCNCA,全国老龄工作委员会办公室) and the China Association for Ageing (CAA,中国老龄协会). OCNCA was led by the Ministry of Civil Affairs until March 2018, then by the National Health Commission, the implication being that ageing is also a health issue and can be more effectively managed under a health organisation. Ageing can be managed with disease prevention and medical intervention.

On 31 May 2018, the National Healthcare Security Administration (国家医疗保障局) was established under the State Council as an independent government office. Amongst others, the office integrates duties related to medical insurance, which had been managed by the Ministry of Human Resources and Social Security, Ministry of Civil Affairs, the former National Health and Family Planning Commission, and National Development and Reform Commission. The urban employee and urban resident basic medical insurances and the new rural cooperative medical insurance are now under one office. It also monitors and manages medical insurance funds and has the power to adjust prices of medicine and medical services. The purpose of the office is to manage medical care and issues more efficiently, and to allow possible changes or backup for the long-term care system or insurance system.

3.2 Policy and regulation formulation benefiting care of the elderly

Four important policies or initiatives that make long-term care of the elderly easier directly or indirectly are discussed: (1) nationwide education on ageing (2018), (2) the 13th 5-year plan (2016–2020), (3) nursing caregiver standards (2011), and (4) development of the nursing care service industry (2018).

First, nationwide education to raise public awareness of ageing was started by OCNCA in January 2018 to create an elderly-friendly social environment by 2020 (Office of China National Committee on Aging, 2018). The campaign targets cadres, youth, and the elderly, disseminating information on ageing, policies and regulations on ageing, and achievements in coping with

ageing; emphasising filial piety and respect for the elderly; and creating a positive attitude towards ageing. Everyone should know how serious population ageing is and what the challenges are: one is care for the elderly, including long-term care.

Second, the goals of the 13th national 5-year plan for the development of ageing-related works and the construction of old-age care system (2016–2020) (十三五国家老龄事业发展和养老体系建设规划) must be implemented to ensure a well-structured old-age care system. Created by the State Council, the plan has specific goals: by 2020, a fairer and more sustainable social security system with multiple pillars and full coverage; a family-based old-age care service system supported by communities and supplemented by institutions; social structural change to enable government and market to function well together; and a social environment that is friendly to the ageing and the old-age care system (Zhou, 2017). Table 2.1 presents the concrete goals of the plan.

Table 2.1. Major Indicators of the 13th National 5-year Plan for the Development of Ageing-related Works and the Construction of Old-age Care System (2016–2020)

Type	Indicator	Goal
Social security	Basic pension enrolment	90%
	Basic medical insurance enrolment	95%+
Old-age Care services	Government-owned beds	<50%
	Nursing-care beds	>30%
Health support	Health quality of the elderly	To 10%
	Geriatrics department at level-2 general hospitals	> 35%
	Health management of older people aged 65+	70%
Spiritual-cultural life	Schools for the aged in counties and townships	50%
	Regular participation in education of the elderly	>20%
Social participation	Elderly volunteers as part of the total elderly population	12%
	Grassroots ageing associations in rural and urban communities	> 90%
Guaranteed investment	Welfare lottery's input	>50%

Source: Reorganised based on data from Zhou, 2017.

The 5-year plan also sets goals for community old-age care services and an Internet+ care system. The target population is old people with disabilities and/or living alone. Assisted services include food, cleaning, transportation, bathing, doctor visits, and day-time care. The government plans to build a community old-age care service information platform, emergency call system, and an emergency rescue service system. The Internet+ care system will provide distance reminding and control, auto alarm and management, dynamic monitoring and recording, and virtual nursing homes.

Third, the national standards for nursing caregivers（养老护理员国家职业标准）were issued by the Ministry of Human Resources and Social Security in February 2002 and revised in 2011

(Beijing College of Social Administration, 2012) They define the occupation and its ranks and their professional training requirements. The quality of caregivers has improved every year. They need to pass a professional test and obtain a certificate so that the government can regulate them and enhance their quality.

Fourth, the first-ever guidelines on promoting reform and development of the nursing care service industry (July 2018, 关于促进护理服务业改革与发展的指导意见) were issued by 11 government departments or offices (National Health Commission, 2018). The guidelines intend to build a top-down nursing care system to meet the needs of home medical care service, home care service, and rehabilitation, especially amongst the elderly. Long-term care issues discussed in the guidelines are the following:

(1) Build a better nursing care system with in-home care as a basis, community care as a platform, and institutional care as support. The system should provide emergency, recovery, stability, and end-of-life care and extend nursing care services to the community and family.
(2) Provide proper nursing care services, including by substantially increasing the number of continuous medical care facilities (nursing homes, nursing care centres, palliative care facilities); expanding services (rehabilitation, old-age nursing care, disabled care, maternity care, palliative care); and further develop community and home care services.
(3) Encourage grade-2 hospitals to work with facilities for the elderly; provide nursing care, rehabilitation services, chronic disease management; and Chinese medicine health care. Encourage qualified old-age care facilities to set up clinics and nursing care stations to provide basic medical care.
(4) Speed up training for assistant nurses (辅助型护理人员，简称护理员）by encouraging qualified schools, professional associations, and vocational training institutions to train them. This is a new and special focus in developing the nursing care system as the family may not provide sufficient care for their aged and frail family members.

3.3 Regional pilot project of long-term care insurance system initiated

Learning from other countries, China started a pilot project of long-term care insurance in 2016 in 15 cities and regions[1], supported by the Ministry of Human Resources and Social Security (Medical Insurance Division, 2016). The system provides urban residents with basic worker's medical insurance. The project's goals were to take 1 or 2 years to test the possibility of building a new insurance system and to accumulate policy experience (scope of security, fund source, level of payment); standard evaluation system of care need and level of need, quality evaluation and management of service institutions and personnel, and standards of managing and operating an insurance system. In 2020, the project added 14 more cities or regions into the existing system (National Healthcare Security Administration, 2020-9-16). The project is ongoing and information on the project's effects is limited. The Ministry of Human Resources and Social Security stated the pilot project was proceeding smoothly (Medical Insurance Division, 2018). By the end of 2017, 44 million project city residents had joined the insurance program; 75,000 individuals benefited; and the system paid 70% or more of the care cost (an average CNY7,600 per person). More data is being collected, studied, and analysed, and we should have more information in the near future.

[1] Chengde, Changchun, Qiqihaer, Shanghai, Nantong and Suzhou, Ningbo, Anqing, Shangrao, Qingdao, Jingen, Guangzhou, Chongqing, Chengdu, Shihezi.

4. Summary

China is an ageing society whose population will grow fast. The government has always addressed ageing but not as seriously or in such a goal-oriented way as today does. In recent years, we have observed institutional changes in government agencies working in the ageing field. With the establishment of the Ageing and Health Division within the National Health Commission and of the National Medical Security Administration under the State Council, we expect stronger leadership in the field of ageing. There are, however, other government departments that also work on different aspects of ageing.

Through recent policies and regulations, amongst other initiatives, the government promotes an elderly-friendly social environment a positive attitudes towards ageing. The 13th national 5-year plan for the development of ageing-related works and the construction of old-age care system2016–2020) has built a structure of old-age care, including social security, care services, health support, support for daily and cultural life, and social participation. 'Nursing caregiver' became a profession in 2002, guided by occupational standards since 2011. In July 2018, the nursing care service industry became a target of reform. The government aims to provide high-quality continuous care, including emergency, rehabilitation, and end-of-life care, for the elderly, which requires high-quality personnel. We expect more assistant nurses to be trained.

Long-term care insurance is new although China has been learning from other countries, especially those with similar cultures, such as Japan and the Republic of Korea. In 2016, the Ministry of Human Resources and Social Security started a pilot long-term care insurance system in various types of urban areas, hoping to generate information to establish a nation-wide system. With support from the public and the government, we hope that China will respond to ageing efficiently and cost-effectively in the next few decades.

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CHAPTER 3

Long-term Care Provision in Japan

Koichi Ogasawara

1. Historical Background and Context of Long-term Care Insurance

In 2000, the universal public insurance system for long-term care for the elderly and those with chronic diseases started as Japan witnessed a rapidly ageing population and socialised long-term care service provision became an urgent need. Institutional long-term care was set up in 1874 just after the Meiji Restoration as part of public assistance to the poor, the fragile, and those with no relatives to rely on. In 1933, they were accommodated in publicly funded relief facilities and hospitals and in private relief organisations. The pre–World War II idea of providing public financial support to and regulating private welfare entities and of supporting the physical and daily needs of the elderly has been continued after the war.

In 1962, the universal medical insurance system was introduced, covering long-term medical needs. In 1963, the Elderly Welfare Law introduced new approaches to long-term care for all the elderly, not just the poor, and launched care at home (home help) (Table 3.1). From 1963 to 2000, the long-term care system was based on separate medical insurance services and institutional welfare care services. The medical clinical service system for long-term recuperation of the elderly and the welfare care service for the elderly needing long-term care evolved in parallel. Those with long-term care needs, however, prefer to use medical rather than welfare services because it is simpler and also because of the stigma attached to welfare services. Along with rapid ageing (the elderly who are 65 years old or above made up 7% of the population in 1970 and 14% in 1996) and the deterioration of families' ability to provide domestic care fostered overdependence on medical insurance, which resulted in disruptive increases in national medical expenses. The insurance cost was allocated to employers, who shouldered 50% of the medical insurance premium.

Social welfare reform in 1990 required all municipal governments to prepare long-term care service infrastructure, mainly by improving community-based care service and introducing private resources into care services. Socialising long-term care resulted in (1) creating a mechanism of universal provision of long-term care by setting up an independent long-term care insurance system that exempted companies and employers from monetary contribution, (2) giving caregivers wider employment options through social care services or stay-in care, and (3) devolving service management to municipalities because of geographic and demographic differences in ageing and care needs and because local planning and governance of daily life support and community-oriented service provision can be profitable.

Table 3.1. Institutionalising Long-term Care – Timeline

Before 1963	Long-term care is part of public assistance
1962	Universal health and medical social insurance established together with pension insurance scheme
1963	Elderly welfare service law enacted • Intensive LTC facilities established • Home-helping service provided
1963–2000	Dual system of LTC by medical providers and the welfare system
1982	Health and Medical Services Law enacted • Medical spending cuts, with universal preventive services
1989–1999	LTC provision universalised • LTC service infrastructure enhanced • LTC at home improved
1995–1996	Critical policies drawn up to universalise service
1997	LTC Insurance Act passed (enforced in 2000) • Quasi-market and socialised LTC
2005–2018	Shifting towards community comprehensive care system

2. Institutional Framework of Long-term Care

The Long-term Care Insurance Law was enacted in 1997 and, after a 3-year trial, fully implemented in 2000. The system's basic concepts are (1) support to enable independent living and security, from primary (preventive) care to terminal care; (2) guarantee of user's choice of services and user–expert collaboration to create the service process; and (3) public, not social, insurance funded equally by public spending and insurance premiums. Because the system reflects social welfare practice, the social work function of supporting human autonomy and independent living is inevitably embedded in it. Therefore, preventive primary care, daily living support, ecological coordination, community living, planning by care managers, and consultation of clients about their own care, amongst others, are the core categories of long-term care. Strictly interpreted, these are substantially living-support services, not long-term care. Because the system is compulsory, 50% funded by public taxes (25% by the central government, 12.5% each by prefectural and municipal governments) and 50% by insurance charges on those aged 40–64 and 65 and above, LTC insurance prioritises medical services for those aged 65 and above and services for eligible handicapped persons.

Japan's long-term care insurance system is unique and may be (1) single, (2) universal, (3) independent, or (4) locality based.

(1) Single means all-inclusive provision of medical and co-medical clinical practices, physical and mental care, counselling and guidance, care management, social work (including social participation and legal affairs), comprehensively packaged. Single insurance promotes effective and efficient resource allocation and better services, and separates long-term medical spending from medical insurance.[1]

[1] The medical insurance system has the following characteristics. (1) It has several kinds of insurance: medical insurance for self-employment, health insurance established by big companies, social insurance for employees of small and medium-sized enterprises, health insurance for civil servants, amongst others. Some insurers are subsidised by tax revenue, but not big companies because of their strong financial base. (2) The medical insurance fee is flat nationwide and applied to any insurer. Medical facilities submit claims to insurers to ask for the payment in accordance with each item of the medical services provided. Amounts claimed have had no maximum limit (although that is changing now and lumpsum payment system in accordance with the status of patients is being introduced). As a result, many people who do not need intensive medical care but do need LTC remained hospitalised, benefiting hospitals and patients but leading to skyrocketing 'medical expenditures' (the amount paid through medical insurance, including for such not-necessarily-hospitalised patients).

(2) Universal means that all citizens aged 40 and above must contribute to the long-term care insurance fund as set by each municipal government, so that anyone who needs long-term care services can utilise them as assessed by a commission. There are two preventive levels and five care support levels. Insurance payments to the service providers are calculated by service points used, and users are free to choose services within the limits of service points of each level, conditional on 10% direct charge payment to the service providers. Now direct charge payments are 20% (since 2012) and 30% for those who can afford it (from 2018).

(3) Independent means that the system is independent from the medical insurance system: the municipal government is an independent insurer, service users are limited to the elderly, and the insurance premium is charged to those aged 40 and above. The insurance premium charge system is also independent from that of medical insurance, enhancing quasi-market service consumption through a consumer contract between service user and provider, and deregulating welfare service providers. This system also improves consumer protection, claiming procedure, service information, quality of service, public administrative planning of service resource rationing, amongst others.

(4) Locality based means each municipal government is responsible for providing insurance service and collects contributions from all local inhabitants aged 40 and above, without exemption. The municipal government insures long-term care, charges insurance premiums and controls the fund, decides on the charge rate every 3 years, draws up administrative plans every 3 years, allocates resources, and organises community care meetings of service providers and multidisciplinary experts.

3. Practices of Long-term Care Services

3.1. Updated Figures: Increasing Institutional Costs

Table 3.2 shows the latest figures on long-term care

Although long-term care insurance is a universal system, only 18.1% of the elderly are certified users. Those aged 85 years and above, especially those in their 90s, are more likely to be the beneficiaries of LTCI services. Nevertheless, the total insurance budget for 2018 was about JPY10 trillion, equivalent to the combined budgets for education, science, culture, and sports, and for national defence. Total spending is estimated to double by 2025. The average insurance premium per elderly person per month in 2018 was JPY5,869 or about US$52, which is double that in 2000. The highest municipal charge is JPY9,800 or US$87. The average national pension (non-employee and self-owned business) payment per person per month in 2017 was JPY55,000 or US$491. Average charges in 2018 for the advanced-elderly medical service system for people aged 75 and above, managed by 47 prefectural governments, was JPY5,857 or US$52. Those 75 years and above have to contribute more than 20% of their pensions (in the case of national

Such medical expenditure, which is spent for LTC and supposed to be categorised as social welfare cost, must be separated from medical insurance and placed under LTC insurance. Medical expenditure cost in Japan is about JPY40 trillion per year, while LTC cost is JPY10 trillion per year. The introduction of LTC succeeded in separating them. The global standard is to exclude LTC cost from 'medical expenditure'. As a result of such separation, the burden on big companies' and civil servants' medical insurers has lightened, because the premium of LTC insurance is not covered by companies but by individuals. Of the budget of LTC insurance, 50% is covered by tax revenue (national government 25%, prefecture 12.5%, and municipalities 12.5%), the rest 50% by individuals.

Table 3.2. Latest Figures on Long-term Care (as of December 2018, unless otherwise noted)

Proportion of population 65 years and above				28.2%			
Number of insured 65 years and above				35.14 million			
Number of the certified as needing LTC or support				6.578 million (18.3% of the insured of LTCI category 1) Male 2.069 million Female 4.509 million			
Number of service users				At-home services 3.775 million (home visits, day care, rehabilitation)			
Multifunctional integrated community care				0.873 million			
Care and rehabilitation facility services				0.944 million			
Proportion of service users by age and gender to the total population of each age and gender group (as of November 2017)							
Ages	65–69	70–74	75–79	80–84	85–89	90–94	95 above
Male	2.4 (%)	4.4 (%)	8.1 (%)	16.0 (%)	29.9 (%)	48.0 (%)	70.9 (%)
Female	1.8 (%)	4.1 (%)	9.7 (%)	23.4 (%)	44.9 (%)	65.3 (%)	86.8 (%)

Source: Statistics Bureau, Ministry of Internal Affairs and Communications (2018); Social Statistics Office to the Director-General for Statistics and Information Policy, Ministry of Health, Labour and Welfare of Japan (2018); and Ministry of Health, Labour, and Welfare (2018.

pension scheme) every month to long-term care and medical service insurances whether they use the services or not.

3.2. Marketisation

In 2016, there were 12,865 institutional and 148,014 non-institutional care service providers, including preventive rehabilitation service providers. More than half were in the private sector. There are 233,239 private residential homes with care services outside long-term care insurance, whilst there were 12,869 care facilities covered by long-term care insurance.

Insurance services are shifting from institutional to non-institutional care, relying more on family domestic resources. The long-term care provision system is a mixed system of insurance and business, of institutions and non-institutions, and of public and private sectors, including family resource integration.

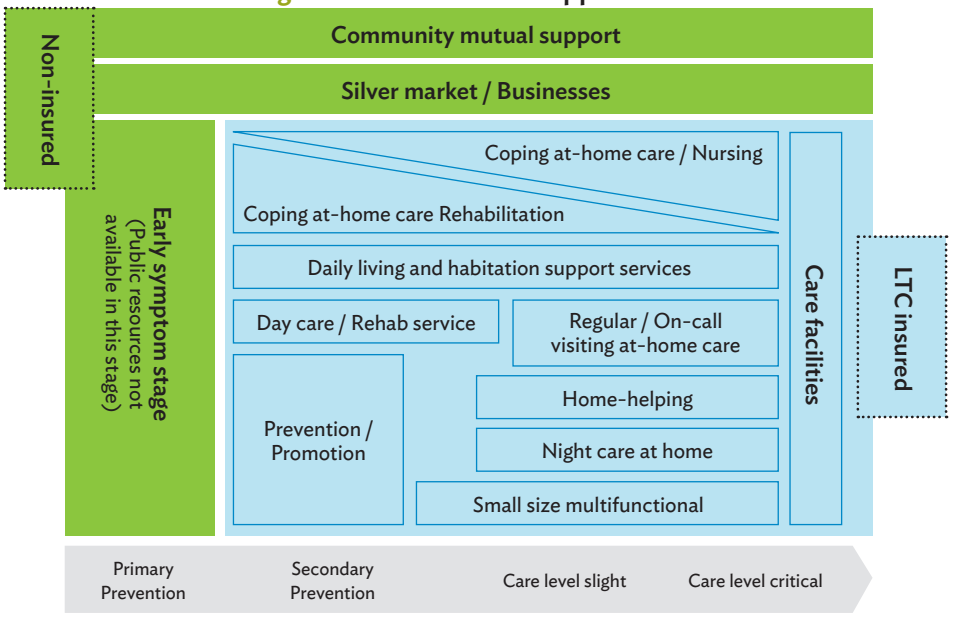
Considering that long-term care spending is expected to double in 2025 because of the rapid increase of the population aged 75 and above, and that, by 2040, one-third of the population is estimated to be aged 65 and above, and that the birth rate is declining, privatisation of service providers and promotion of services outside the insurance system are inevitable. The single solution for the crisis is to share responsibility and resource contribution amongst the public–private, profit–non-profit, and even official–folk sectors with the locality-based comprehensive sectoral mix.

3.3. Challenge in Sectoral Mix

Facing increasing institutional costs and shortages in formal insurance services, the government enhances the sectoral-mix approach to benefit clients and develop the best solutions for individual cases. The idea of community comprehensive care was emphasised from 2008 at the theoretical experimental level and from 2012 at the policy level. The social security reform enhancement law of 2012 and the long-term care reform act of 2012 introduced community comprehensive care as a goal.

Figure 3.1 shows wholesale sectoral-mix pattern of the policy.

Figure 3.1. Sectoral-Mix approach



Source: Author.

The sectoral-mix approach is orthodoxy in public management and nothing new in long-term care policy. What is new is that it is not simple deregulation or privatisation but incorporation of non-insured areas into long-term care insurance system management.

Two areas are to be incorporated. One is the 'missing market' or 'early symptom stage', where formal services are absent. This stage is critical to prevent the need for care, and various community-based activities and market services have been innovating in this area. The second is mutual support in the folk and private sectors, which supports various attractive services and practices to improve quality of life .

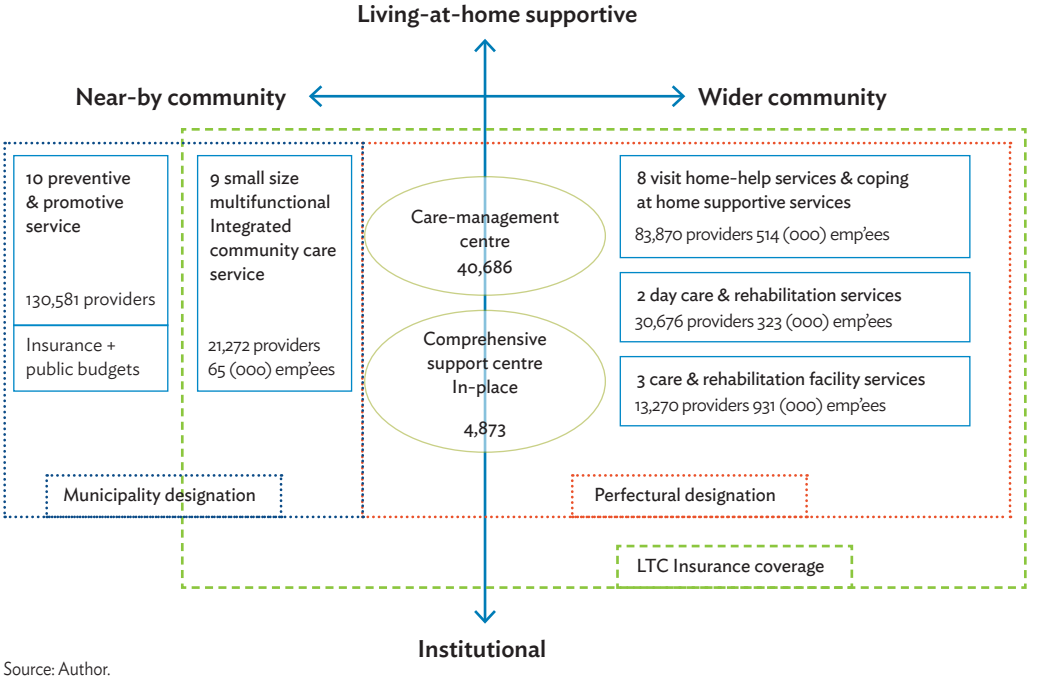
The key to incorporate the two areas into an insurance managerial system is care management. Guidelines from the Ministry of Health, Labour, and Welfare requests care managers to use non-insurance services and voluntary mutual support practices in formal care planning, and asks that non-insurance services coordinate within long-term care institutional infrastructure.

3.4. Community Care Management

Figure 3.2 shows the whole-service provision structure under long-term care insurance.

The types of services provided in the community comprehensive care network consist of 'near-by community', 'wider community', and 'institutional'. Services are vertically and horizontally integrated. A comprehensive support centre (CSC) is the central control and works with a highly trained senior care manager, social worker, and public health specialist together with a daily-living coordinator to counsel and guide the client, provide preventive care and comprehensive and continuous care, and protect the client's human rights. The CSC is also the gateway to long-term care insurance service, a one-stop centre for long-term care matters, and an organiser of community care meetings to find a team solution to complex and difficult cases. The CSC analyses the community's challenges to advocate improvement in service and clinical quality and reform in municipal long-term care policy.

Figure 3.2. LTC Insurance Service Complex (community comprehensive care service network)



Source: Author.

There are two types of care management in the LTC insurance system. One is that practiced in 'three types of care and rehabilitation facilities' (Figure 3.2, right bottom blue rectangle). These facilities accommodate older people who need intensive care (certified as in the higher care-need level) and beneficiaries are all institutionalised. Their care plans must be made by care managers, who are employed by the facilities; independent (outside the facilities) care managers may not make the care plans. Beneficiaries of other facilities and LTC providers designated by the LTC insurance system are allowed contract with any certified care manager.

The three types of care and rehabilitation facilities have their own care management centres. The over 40,000 centres (Figure 3.2) plan services other than facilities. The comprehensive support centre passes individual cases to the care management centre, supports and advises it on improving quality, frequently invites it to community care meetings, and monitors how it solves cases.

4. Linking with Medical Reform

The medical and long-term care systems liaise with each other. Reforms to rationalise the medical system will be completed by 2024. The reform will enhance functional segmentation and specialisation of hospitals, from the acute to the terminal stages, and strengthen the links amongst medical service facilities to shorten hospital stays and improve the bed turnover rate.

A growing number of patients who still need medical monitoring will be obliged to be discharged from hospitals because rehabilitation-oriented medical service facilities and convalescent-responsive medical resources are insufficient. The number of hospital beds for dying people is also insufficient. About 80% of death in Japan take place in hospitals now. If this percentage does not change though the government encourages to die at home or any residential facilities to alleviate the shortage of hospital beds and to reduce the medical expenditure, more hospital bets will be required and the hospital beds which are registered as the beds for general patients should be converted into the beds for exclusive terminal-care use (In Japan's medical service system, the use of hospital beds should be registered depending on its usage). Of the growing number of people outplaced from medical institutions, most are elderly and must be placed elsewhere and receive long-term insurance services.

The Community Comprehensive Care Strengthening Act of 2017 and related Medical Law reform, together with the medical service fee revision in 2018, aim to accelerate the functional link between the medical service and long-term care service systems. The medical service system is a vertically integrated from acute to terminal care, whilst the long-term care service system is a community-based horizontal functional liaison (Figure 3.2). People prefer to stay in hospital if they become disabled by senility or senility-related diseases (including stroke, bone fracture, amongst others) and are unable to live independently. Because of rapid population ageing, however, they cannot be accommodated. Their continued stay in hospital will affect the ability of hospitals to provide medical care or even hinder acute care, which is the main role of hospitals. The cost of medical care (even if provided to clients who need only hospitalisation and not need acute care) is much higher than that of LTC. Medical service systems (covered by medical insurance) and LTC services (covered by LTC insurance), therefore, must establish a sustainable

system to care for older people. People who no longer need acute care in hospitals must be smoothly transferred to LTC facilities. This means that LTC services, particularly community and at-home types, must support the client's recovery and recuperation, which is challenging.

5. Quiet but Fundamental Transformation of Long-term Care

After almost 2 decades, long-term care insurance faces some fundamental systemic deadlocks: geographical and demographical partialities in service provision, limitation of service users, rising total cost, limited bearing ability of the insured population, and the need to extend service liaison with non-insured sectors. These are the challenges to long-term care insurance – single, universal, and locality based. The LTC insurance system faces the pressure to coordinate with medical insurance because it is encouraged to promote the seamless transfer from acute care facilities to LTC facilities and to avoid the overlapping of services, though the LTC insurance was established to achieve the 'independence' of LTC services from medical care services.

Disparities in finance and administration of the locality-based system are far more serious than initially estimated. Within disadvantaged municipalities or marginalised regions, 896 municipalities out of 1,718 are predicted to be in crisis by 2040 because of dynamic depopulation (especially the younger female population) and continuous ageing together with loss of economic sustainability. In urban–suburb municipalities, the ageing rate by 2030 will be far beyond anything ever experienced because of the overconcentration of post-war baby boomers. These structural changes are reflected in the diversification of municipal managerial strategies and resource allocation for long-term care insurance. The locality-based system is now fettered to municipality-managed insurance.

The sectoral mix for integrating non-insurance resources into insurance system management mechanisms, comprehensive care focusing on daily living in small communities and emphasis on the CSC's role in encouraging stakeholders' cooperation to rationalise service provision, and improvement of medical and long-term care service systems are all part of the quiet but fundamental transformation of long-term care provision.

Whether medical and long-term care insurances will integrate, whether long-term care services will be universalised to cover all generations' needs now covered by medical insurance, whether insurers will consolidate into a single or several regional administrative agencies, whether the CSC will become a more comprehensive community health and social service centre – all these issues will define the transformation of Japan's system.

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CHAPTER 4

Policy Issues of Long-term Care for Older People in the Republic of Korea

Hyunsook Yoon

1. Population Ageing

Population ageing in Korea is projected to be the most rapid amongst Organisation for Economic Co-operation and Development (OECD) countries between 2000 and 2050. The population will peak at 50 million in 2020 and then decline about 15% by mid-century, even as the proportion of the older population grows. The median age, 20 years in 1960, reached 38 in 2010 and is likely to be nearly 50 in 2030, suggesting fundamental changes in the country's socio-economic structure. The proportion aged 65 and older doubled from 7% in 2000 to 14% by 2018; in contrast, this transition is projected to take 71 years in the United States and took 115 years in France. In only 8 more years (compared with up to 40 years in major European countries), by 2026, the proportion of the elderly in Korea will increase from 14% to 20%.

The 'compressed population ageing' in Korea has been driven by increasing life expectancy and falling fertility. Life expectancy increased by 26 years from 55 in 1960 to 81 in 2020. A more important factor is the fall in the fertility rate, from 6.0 in 1960 to 1.5 in 2000 and 0.90 in 2020, the lowest in OECD countries. This dramatic decline may have resulted from heightened economic uncertainty in the wake of the 1997 Asian financial crisis and the 2008 global financial crisis.

1.1. Long-term Care System

In July 2008, Korea introduced a long-term care insurance (LTCI) system to provide security to older people who cannot take care of themselves due to physical weakness or geriatric diseases and to reduce the burden on their families. In addition to demographic changes, family structures and attitudes towards care for older people have changed during the last decades. As female labour participation increased, families became smaller, and informal caregivers became less available.

Table 4.1. Population Ageing in the Republic of Korea

	Population (millions)	Growth rate (%)[a]	Fertility rate [b]	Life expectancy (years)	Median age (years)	Proportion of elderly (%)[c]
1960	25.0	2.3	6.0	55.3	19.9	2.9
1970	31.5	1.8	4.5	63.2	19.0	3.1
1980	37.4	1.5	2.7	65.8	22.2	3.8
1990	43.4	0.6	1.6	71.3	27.0	5.1
2000	46.1	0.6	1.5	75.9	31.8	7.3
2010	49.2	0.1	1.2	79.1	37.9	10.9
2020	50.0	-0.1	1.2	81.0	43.7	15.7
2030	49.3	-0.5	1.3	81.9	49.0	24.1
2040	46.7	-0.5	1.3	82.6	53.1	32.0
2050	42.3	...	1.3	83.3	56.2	37.3

[a] The annual average growth rate for the decade in the row for 1960, for example, shows the rate for the decade 1960–1970.

[b] The average number of children that a woman can expect to bear during her lifetime.

[c] The number of persons over the age of 65 as a percentage of the total population.

Source: Korea National Statistical Office. Projections for 2005–2050.

There were some debates on whether Korea, whose proportion of older people was still lower than that in OECD countries, should have a mandatory and universal LTCI. A progressive government played a key role in introducing universal LTCI to cover all older people who need LTC. Kim Dae Jung, who became president in early 1998, had a strong interest in progressive welfare state policies. Formal discussion of LTCI started in 2000 when the Ministry of Health and Welfare appointed the Planning Committee for Elderly Long-term Care. The provision of LTC to expand care for older people had broad appeal and did not encounter political opposition (Jeon and Kwon, 2017).

Financing

The contribution rate is 6.55% of health insurance premiums; in other words, anyone who contributes to health insurance also contributes to LTCI. The financing mix is composed of contributions (60%–65%), tax subsidies (20%), and co-payment by service users, which is 20% for institutional services and 15% for home-based services.

Administration

Funding of LTCI is separate from that of the National Health Insurance (NHI), but both are administered by the NHI Service (NHIS) to reduce administrative costs.

Eligibility

To use LTC services, individuals must pass a needs assessment to determine the functional status of physical, cognitive, behaviour, nursing care, and rehabilitative characteristics, using 52 items. The eligible group was classified into five levels for those with dementia. The population coverage of LTCI was increased from 3.1% to 10.1% of older people from 2008 to 2019.

Benefits

LTCI provides institutional and home-based care and cash benefits. Home-based care consists of bathing, nursing, day and night care, short-term care, and assistive devices (e.g., walker or cane, wheelchairs, pressure relief mattresses). Cash benefits are available only in exceptional cases, for example, when no service providers are accessible in the region. The amount of benefits depends on the eligibility level, and the ceiling on benefit coverage differs by level. Utilisation of home-based care increased from 61.4% in 2008 to 67.92% in 2016.

Table 4.2. Long-term Care Institutions and Home-Based Care

- 97% are private agencies (56% individuals, 41% private organisations)
- 18% newly opened, 12% closed in 2014
- 82% occupation rate due to competition with long-term care hospitals

	2010	2012	2014
Institutions (no.)	3,751	4,331	4,875
Beds (no.)	116,782	131,761	150,579
Occupied beds (no.)	88,832	107,615	123,814
Occupancy (%)	76.1	81.7	82.2

- 99% are private agencies (84% individuals, 15% private organisations)
- Small number of elderly (26) cared for by one home-based care agency
- 30% newly opened, 19% closed in 2014

	2010	2012	2014
Home-visit care	20.7	22.3	25.0
Home-visit bathing	9.2	9.9	10.2
Home-visit nursing	11.8	13.7	15.0
Day and night care	10.9	12.7	15.3
Short-term care	7.2	9.0	10.1

Sources: Author.

1.2. Long-term Care Service Delivery

Long-term care providers

After the introduction of LTCI, the number of LTC providers rapidly expanded from 6,618 in 2008 to 14,211 in 2016, and from 1,700 home-based care agencies in 2008 to 5,187 in 2016. Whilst the utilisation rate of institutional care decreased from 38.6% in 2008 to 32.03% in 2016, the utilisation rate of home-based care increased from 61.4% in 2008 to 67.92% in 2016.

The oversupply of LTC providers has led to problems. The number of providers exceeds demand and there is intense competition amongst them to recruit beneficiaries. One common strategy used by providers is to offer beneficiaries reduced co-payment, which has resulted in reduced quality of care.

Long-term care workers

The oversupply of LTC providers also led to the oversupply of service workers, who include care workers (90.1%), social workers (4.1%), and nurses (3.5%). The number of care workers rapidly increased from 176,500 in 2008 to 301,700 (almost double) in 2016 and the number of nurse aides increased from 4,200 to 9,770, whilst the number of registered nurses decreased from 3,400 to 2,800.

Quality evaluation system

To assure LTC quality LTC, NHIS implemented a quality evaluation system in 2009. The number of quality indicators varies by type of service provider: for example, 88 items for institutional care and 32–59 items for home-based care are grouped under five domains of quality measurement: management of institutions, environment and safety, rights and responsibilities, process of services, and outcome of services.

1.3. Policy issues of the Long-term Care Insurance system

Lack of coordination between healthcare and long-term care

Lengthy hospitalisation (often social admissions who do not require medical care) is due to limited coordination with LTCI. NHI's benefits package is more generous than LTCI's. The cost of hospital stay is much higher than that of LTC institutions, increasing healthcare expenditures. LTC institutions (covered by LTCI) and LTC hospitals (covered by NHI) have overlapping services for older people with similar health and functional status, which resulted in persistent social admissions in LTC hospitals amongst older people with lower medical care needs. A significant proportion of older people with clinical care needs, however, stay in LTC institutions where healthcare services are not provided (Jeon and Kwon, 2017).

Primary care providers should play a key role in prevention and in promotion of health and in overcoming the inefficiencies of hospital-centric care. If home-based care services can be linked with community-based primary care, the health and functional status of older people will improve and expensive acute hospitalisation and institutional care use be reduced. Service programs in day-care centres and home-visit nursing, in collaboration with primary-care doctors, are needed.

Oversupply of long-term care providers

The number of beds in LTC institutions almost tripled from 58,000 in 2008 to 168,000 in 2016 and the number of beds in LTC hospitals more than quadrupled from 60,000 in 2008 to 255,000 in 2016 (more than quadrupled). Several institutional factors contribute to persistent social admissions in LTC hospitals. Most LTC hospitals and LTC institutions are private, and more patients and residents means profits. The competition between LTC hospitals and LTC institutions has been fierce. Of LTC institutions, 97% are private agencies (56% owned by individuals and 41% owned by private organisations). In 2014, 18% were newly opened and 12% were closed. The occupancy rate is 82% due to competition with LTC hospitals. In case of home-based care agencies, 99% are private (84% owned by individuals and 15% owned by private organisations). An average of 26 elderly were cared for by one home-based care agency. In 2014, 30% of LTC institutions were newly opened and 19% closed.

Low qualification of service workers

The LTC workforce has basic quality issues. Those who want to become care workers must complete a 240-hour training course and pass the national qualification examination. The increase in quasi-professional staffing may be due to the small size of institutions. One of the main problems related to care workers is poor working conditions, resulting in low job satisfaction, high turnover rates, and low quality of care.

Most LTC providers are small private for-profit entities that invest minimally in infrastructure and are not financially stable. The rapid increase in LTC providers and service workers was not accompanied by improved quality of care or equitable distribution by region. More than 90% of providers and service workers are from the private sector, and most home-care providers are in urban areas.

Inadequate cooperation between local government and the National Health Insurance System

Although the LTC quality evaluation system was initiated to improve the quality of care, there are still several limitations. The gap between real quality of care and evaluation results exists due to the insufficient number of outcome-based indicators. Inadequate cooperation between local governments and NHIS has been criticised because local governments are not active in controlling the quality of LTC institutions, even though they have the authority to approve or close them.

Concerns about sustainability of financing

Concerns have been raised about the sustainability of the health and LTCI system because of rapidly growing demand and expenditure for geriatric and personal care. Reducing social admissions and strengthening policies for prevention and for health promotion amongst older people might directly or potentially result in financial savings. There is also a trade-off between population coverage and the LTC system's financial sustainability. A strict assessment for eligibility can improve financial sustainability, but the resultant low coverage of the population can limit the capacity of the LTC system to meet the LTC needs of older people. The LTCI covers about 8.7% of older people, which is significantly lower than in OECD countries (average more than 10%).

2. Conclusion

In 2018, the government announced comprehensive community care for older people as a future direction for improving LTC services, based on supporting ageing in place; integrating healthcare, LTC, and welfare services; adopting a care-manager system as service planner, coordinator, and supervisor; establishing community networks; and encouraging community residents' participation. Ageing in place is the ability to remain in one's own home or community despite potential changes in health and functioning in later life. Older residents need to be able to access community support and services, whether by leaving their homes and venturing out or by bringing support and services into their own homes. Older adults' needs can be met through public, non-profit, for-profit, and informal organisations within the community. Whilst research is limited in terms of documenting the direct relationship between these community characteristics and ageing in place, there is evidence that these characteristics can promote the physical, mental, social, and economic health and well-being of older adults, which, in turn, can help them age in place.

Introducing LTCI achieved a great deal. The proportion of older people who benefit from LTC services has increased substantially. Early evaluation studies on LTCI show that it significantly reduced family caregivers' burden, including psychological and financial stress.

LTCI created a framework to provide universal coverage for all older people who require LTC, regardless of income. Rapid population ageing is expected to increase public expenditure on LTC. Korea now confronts difficult challenges in seeking to secure financial stability and quality of care for older people in need of LTC services.

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CHAPTER 5

An Overview of Singapore's Long-term Care System: Towards a Community Model of Care

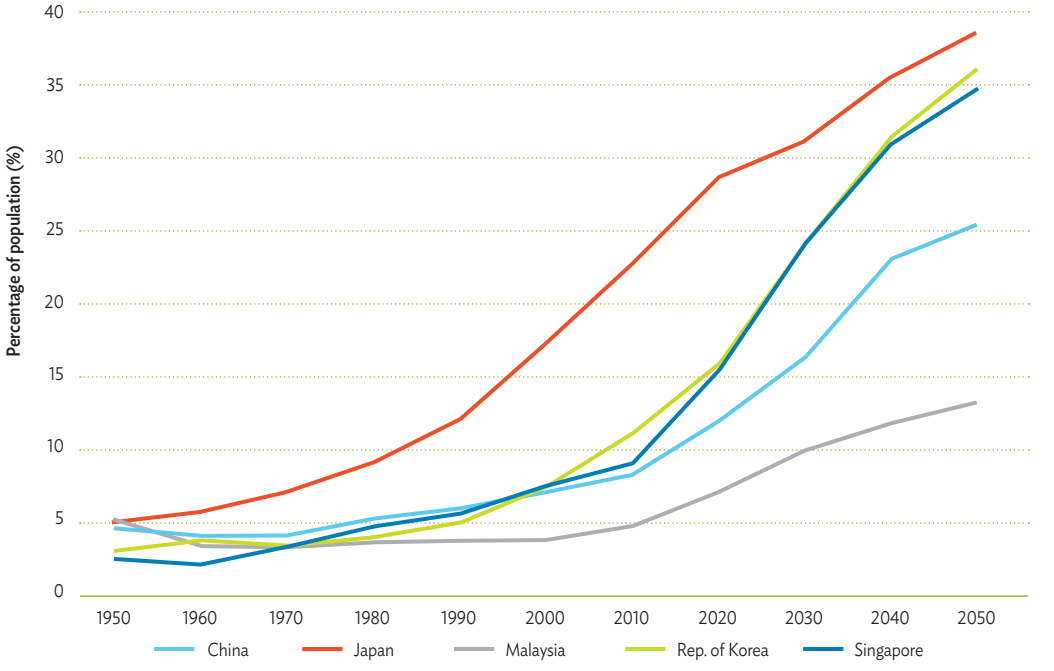
Angelique Chan

Singapore's population is ageing rapidly. By 2030, older adults (65+) will comprise approximately 25% of the total resident population. Population ageing is a result of low fertility rates of under an average of 2.1 births per woman since the 1970s (Figure 5.1). In addition, increasing longevity is translating into the oldest old (80+) being the fastest growing proportion of the population (Figure 5.2). Average life expectancy is 83 years, with women living on average 85 years and men 81 years (Department of Statistics Singapore, 2018). Population ageing has several implications for caregiving in Singapore. First, fewer family members are available to support older adults. Second, a growing sandwich generation is simultaneously caring for children below 12 years old and family members aged 65+. Due to increasing longevity, the period of caregiving has also lengthened, resulting in caregivers' increased financial and emotional burden. Amongst older persons aged 60+ and living at home with limitations on their activities of daily living, the proportion of those with greater limitations (five or more) will double by 2030 (Ansah, 2013). By 2030, average family eldercare is also projected to increase by 41% from 29 to 41 hours per week, which will be disproportionately borne by families with elders with five or more limitations. Recent research shows how family eldercare hours will change if policy and infrastructure change. By making home and community-based services more attractive, average family eldercare will increase from 29 hours per week at present to 40 hours by 2030. Doubling the proportion of families using a foreign domestic worker to assist in eldercare reduces average family eldercare from 29 to 19 hours per week. By increasing nursing home beds as planned, average family eldercare is projected to decrease from 29 to 28 hours per week by 2030. By implementing all policies simultaneously, average family eldercare decreases from 29 to 12 hours per week by 2030 (Ansah et al., 2013).

The Government of Singapore launched the Action Plan for Successful Ageing in 2015 (Ministry of Health, 2015), which outlines 10 areas of focus for policymaking and programme development: employability, lifelong learning, volunteerism, health and wellness, social engagement and inclusion, aged care services, housing transport, public spaces, and research on ageing. This chapter focuses on health and wellness, specifically Singapore's long-term care (LTC) system and the need to develop community-based models of care.

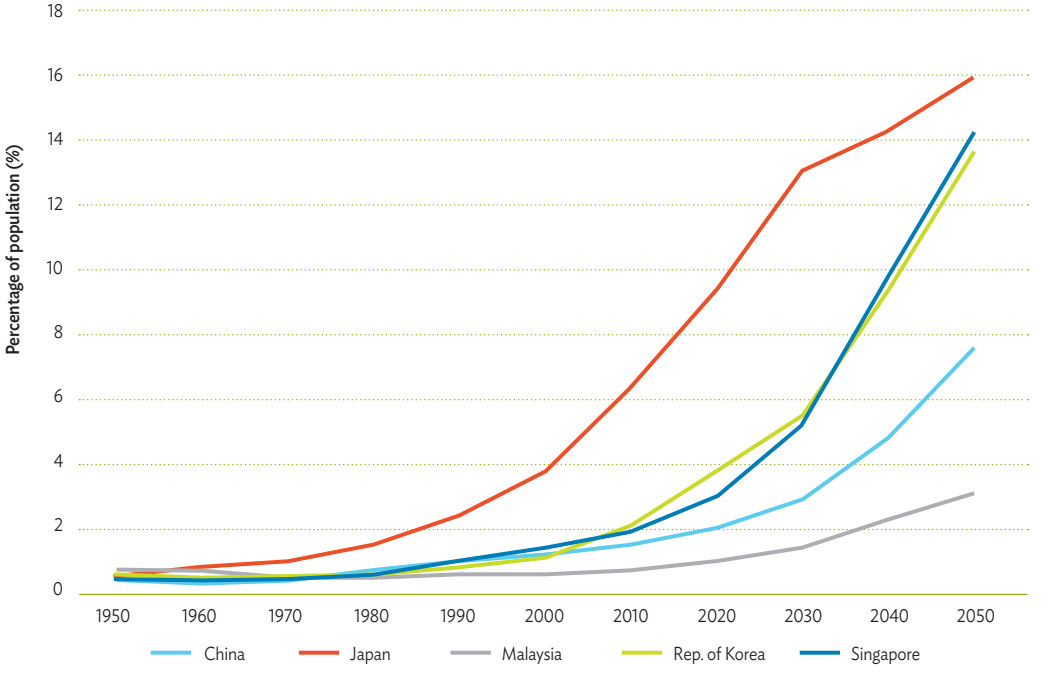
Morbidity patterns in Singapore are changing from acute conditions to more chronic degenerative diseases and disability. The access and quality of long-term care need to be improved. LTC service utilisation in Singapore is lower than in Western societies (Wee et al., 2014).

Figure 5.1. Percentage of Population Aged 65+



Source: Population Division of the Department of Economic and Social Affairs of the United Nation Secretariat, *World Population Prospects: The 2010 Revision,* http://esa.un.org/unpd/wpp/index.htm

Figure 5.2. Percentage of Population Aged 80+



Source: Population Division of the Department of Economic and Social Affairs of the United Nation Secretariat, *World Population Prospects: The 2010 Revision,* http://esa.un.org/unpd/wpp/index.htm

Most families prefer to rely on foreign domestic workers to care for older family members as this is a cost-effective solution. A foreign domestic worker can provide 24/7 care for an older adult as well as perform household chores. Recent research on Singaporeans' attitude towards, and preferences in, LTC shows that most concerns centre around financial accessibility, quality, and convenience (location of LTC services) (Wee et al., 2014). A study showed that in 2014, 90% of eligible recipients took up nursing home referrals, 54% day rehabilitation, 46% dementia day care services, 56% home medical care, 52% home nursing, and 44% home therapy (Liu et al., 2016).

Referrals to LTC services are primarily based on the older person's characteristics, e.g., nursing home referrals are based on the older person's need for care that cannot be provided in the family setting. However, the decision to use LTC services is heavily influenced by caregiver characteristics, e.g., if the caregiver is a spouse or a child (Eom et al., 2016). Spousal caregivers reported significantly lower quality of life than adult child caregivers. Recent research on decision making around the use of LTC services showed that caregivers made 90% of decisions. Caregivers' needs and perceptions of LTC services are important predictors of LTC use over time (Liu et al., 2016).

Current Long-term Care Services

In 2018, the LTC landscape consisted of 71 nursing homes, 2 inpatient hospices, 81 centre-based care facilities, 17 home care providers, and 7 home palliative care providers. A variety of services are provided under the intermediate and LTC frameworks (Tables 5.1 – 5.4). The Ministry of Health launched the Agency for Integrated Care in 2009 to enhance and integrate the LTC sector (Agency for Integrated Care, 2009). The agency aims to improve access to care, and to support patients and their caregivers while developing the primary and community care sectors. Much effort has been invested in developing a robust home- and community-care ecosystem that allows older adults to live in the community for as long as possible.

Enhancing Community-Based Care

In addition to the services and programmes mentioned in Tables 5.1 – 5.4, the government is piloting several community-based programmes to enhance LTC by integrating community social and medical services. The Hospital-to-Home programme (H2H) began in 2017 under the Communities of Care (CoC) model.[1] CoC is being run in five zones in the SingHealth Regional Health System Southeast Region. CoC and H2H aim to integrate health and social care to meet the medical and social needs of high-risk older clients in underprivileged communities. H2H aims to minimise unnecessary hospital utilisation and readmission amongst discharged complex patients and long-stayers (SingHealth, 2017). The programme connects patients with the wider network of primary care providers, social services, and community health partners, and helps patients and caregivers manage medical conditions at home.

[1] https://www.singhealth.com.sg/TomorrowsMed/Article/Pages/returning-home-to-a-community-of-care.aspx

Table 5.1. Home-Based Care Services

Home Nursing	Nursing care, such as dressing wounds, administering injections, and changing feeding tubes
Home Therapy	For homebound clients who need rehabilitation to improve or maintain their activities of daily living
Home Medical	Caters to frail or bedridden clients who need medical consultation and treatment
Home Personal Care	Services such as personal care tasks, assistance with medication and more to meet a client's needs at home
Meals-on-Wheels	Meal delivery for homebound clients
Medical Escort and Transport	For homebound clients unable to get to medical appointments or treatments independently
Temasek Foundation Cares-Care Close to Home	Care coordination and personal care services for the needy and low-income seniors

Source:Agency for Integrated Care (2018).

Table 5.2. Day Care Services

Senior Care Centre	Integrated care services such as day care, dementia day care, day rehabilitation services, and basic nursing services
Day Rehabilitation Centre	Customised exercise and training programmes to improve clients' functional abilities
Dementia Day Care Centre	Structured day care programme for persons with dementia
SPICE (Singapore Programme for Integrated Care for the Elderly)	An integrated centre- and home-based programme providing centre- and home-based services for frail elderly who have high care needs
Social Day Care Centre	Custodial care and maintenance exercises for frail elderly who may need supervision while their families and/or caregivers are at work
Hospice Day Care Centre	Care for terminally ill elderly patients, and caregivers' support such as nursing and medical care to manage the patient's medical condition
Integrated Home and Day Care Package	Home-and centre-based care bundled together to serve needs of seniors more holistically
Taxi Transport Service	Designated taxi drivers to ferry seniors going to and from day care centres

Source: Agency for Integrated Care (2017).

Table 5.3. Community Mental Health Services

CREST (Community Resources and Support Engagement Teams)	A basic community safety network for people with dementia and depression, and caregivers who need the additional support to care for their loved ones
COMIT (COMmunity Intervention Teams)	Provides psycho-social therapeutic intervention for clients with mental health needs and helps their caregivers cope
ASCAT (Assessment and Shared Care Team)	Provides treatment and care to clients with mild and moderate mental health conditions
Dementia Home Intervention Programme	Provides behavioural interventions for clients with dementia and helps caregivers better manage care for their loved ones and themselves
Elder-Sitting Services	For persons with dementia, engaged by elder sitters in meaningful and therapeutic activities to maintain their cognitive function
Dementia-Friendly Communities	Builds a more caring and inclusive society that can support persons with dementia
Mental Health General Practitioner Partnership	Enables general practitioners to provide more holistic care to patients with chronic physical and/or mental illnesses, as referred by public hospitals
Local Community Support Network	Discusses cases encountered in the neighbourhood, identifies care needs, and refers residents to services

Source: Ministry of Health (2018).

Table 5.4. Community-Based Care

Community Health Assist Scheme General Practitioners and Dental Clinics	Enables Singapore citizens of all ages from lower- and middle-income households to receive subsidies for medical and dental care from participating general practitioners and dental clinics near their homes
Aged Care TransitION (ACTION) Project	Helps discharge and arrange community services for the patient and caregiver at home, optimising the patients' health and functional outcomes
Community Case Management Service	Targets frail seniors with multiple health and social care needs, identifies and supports key aspects of seniors' needs in a holistic and person-centred manner
HOlistic care for MEdically advanced patients (HOME) Programme	Provides end-of-life medical and nursing care and psychosocial support for patients and caregivers, as well as advance care planning for terminally ill patients
Community Health Centres	Provides health screenings and conducts health tests through a general practitioner's referral

Source: Ministry of Health (2018).

In the CoC model, nurses are embedded in the community as patient navigators, helping patients find their way around the healthcare system and coordinate care transitions through the entire care continuum to keep patients in the community. The patient navigators also provide clinical assessment and coordinate care. They work with patients beginning at post-discharge, by right-siting to minimise readmission, and by preventing and delaying progression of the condition via health monitoring.

A third programme being piloted in Singapore in 11 sites is the Care Close to Home programme (C2H), which provides home personal care services to older adults (Agency for Integrated Care, 2014). The programme began in 2014 to promote quality of ageing-in-place support and care for low-income older adults living in one- or two-room rental flats with little or no caregiver support. The care team comprises a registered nurse, a programme coordinator, and 4 or 5 healthcare assistants, all of whom are based in senior activity centres in the rental blocks. Preliminary results suggest that older adults feel more at ease having a team stationed within the community because they can easily access the team should they need social or medical care.

Long-term Care Insurance

The government is also taking steps to strengthen the LTC insurance system. The mandate is that meeting LTC needs is a collective responsibility. A range of financing sources support LTC needs, including ElderShield (disability insurance), ElderShield supplements, private disability insurance, private cash savings, central provident fund pay-outs, charity donations, and family support. There are also means-tested subsidies for services, government assistance schemes, and charity and donations. Recent research suggests the following financing mix: out-of-pocket spending (40%), government spending (42%), LTC insurance (9%), and charitable donations (9%). Singapore, with 65% of residents aged 40 to 83 covered by basic LTC insurance, including 22% with supplementary plans, has the highest voluntary LTC insurance rate in the world (Graham and Bilger, 2017).

The main LTC insurance programme, ElderShield, was tweaked in 2018 into a new programme, CareShield Life, under which payouts increase over time, starting at SGD600 per month in 2020 (Ministry of Health, 2018). Pay-outs are increased by 2% each year and begin when an individual has three activity of daily living limitations. All Singaporeans and permanent residents are required to have ElderShield insurance beginning at age 30. Table 5.5 shows the difference between ElderShield and CareShield Life.

The following sources are available for Singaporeans and permanent residents to pay for their LTC needs. CareShield Life is a universal plan for all future cohorts, regardless of disability or financial status. Existing cohorts who are not severely disabled are encouraged to join. The government has announced that no one will lose coverage due to financial difficulties. The second source is MediSave, an individual savings scheme for healthcare needs based on a percentage of employee and employer contributions. Cash withdrawals provide flexibility for different care arrangements and support ageing-in-place. The third source is ElderFund, targeted at those who need further support beyond CareShield and MediSave withdrawals. It also supports individuals who may not be able to join CareShield Life, have low MediSave savings, or have insufficient savings for their care needs. The LTC financing system takes a whole-of-society approach to diversify risk and maintain sustainability.

Table 5.5. Components of ElderShield Vs. CareShield

	ElderShield	CareShield Life
Able to opt out?	Yes	No
Payable by MediSave	Yes	Yes
Premiums start at	40 years old	30 years old
Premiums stop at	65 years old	67 years old (or later according to retirement age)
Annual premiums	SGD175 (men) SGD200 (men)	SGD218 (women) SGD250 (women) - Increase 2% every year
Premiums are paid for (years)	26	38
Government subsidy	No	Yes
Pay-out starts when	Unable to do at least three activities of daily living	
Pay-out amount	SGD400/month	SGD600/month (starting 2020)
Duration of pay-out	6 years	Lifetime

Source: The Straits Times (2018).

Challenges and Solutions

Singapore's population is ageing rapidly, presenting a challenge for policymakers and programme developers. While ageing represents the success derived from economic development, it also requires policy reformulation to capitalise on the benefits of an ageing society. This chapter has focused on enhancing LTC services for older adults. Equally important are policies to extend the retirement age and promote social integration as working and strong social support networks are key to enhancing older adults' well-being. Policy reformulation is in its early stages. There has been a concerted effort to develop and manage LTC services and the associated costs. The solution is to take a whole-of-society approach, combining personal and state contributions to LTC. Quality and convenience still need to be improved to bolster the LTC sector. A recent development is the opening of Kampung Admiralty, Singapore's first assisted-living housing development (Singapore Housing Development Board, 2017). Social and medical care are available in the same housing complex. The complex also includes a child day care centre to foster intergenerational relationships. Early assessments suggest that older adults living in Kampung Admiralty are more likely to frequent services in the community – e.g., the food court – than in other housing estates. One reason is that the food court is now more accessible. Older adults have also reported enjoying interactions with fellow residents and the younger generation. The government is planning to develop more assisted-living housing developments.

Despite concerted efforts to expand the capacity of the LTC sector, informal caregivers continue to act as default care providers. Singapore has a deep tradition of filial piety and policymakers also expect families to act as the primary caregivers for the elderly. Providing more community-based services can have positive mental health outcomes for caregivers in the short and long term (Gitlin, 2006). In response to rapid ageing worldwide, LTC providers will serve an ever-growing population. It is important to note that community-based LTC services are often supplemented by informal caregivers, and it is vital to consider their well-being as we create integrated health systems where caregivers are intimately involved in decision-making and care provision. In the coming years, Singapore will be able to present several models of providing LTC to other societies grappling with the same concerns. The sharing of best practices will be an important step towards achieving a high quality of life for older adults in Asia.

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CHAPTER 6

Long-term Care Policy and Implementation in Thailand

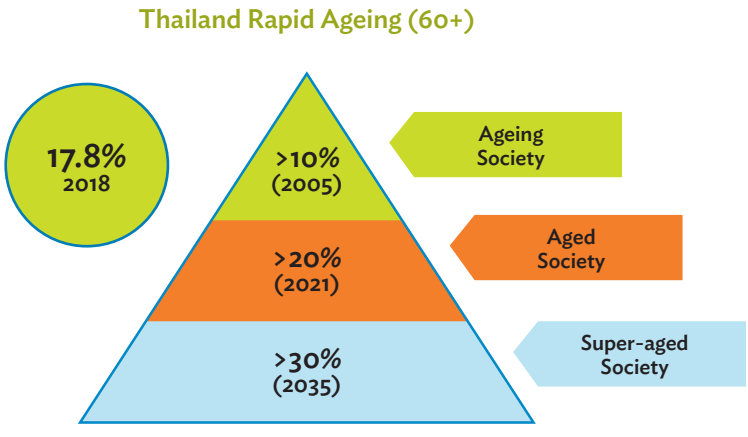
Puangpen Chanprasert

Demographic Data

Thailand's population was 66.2 million in 2018 (Mahidol University, 2018), with children (under 15 years) numbering 11.4 million, the labour force (15–59 years) 43.0 million, and elderly (60 years and over) 11.8 million. Life expectancy at birth is 72.2 years for males and 78.9 years for females, and at 60, 20.2 years for males and 23.6 years for females. The crude birth rate is 10.7 and the crude death rate 8.3 per 1,000 population.

Demographic transition was accompanied by reduced crude birth and death rates. The successful family planning programme resulted in a decline in population growth from 3.4% in 1960 (Barbara Leitch LePoer, ed., 1987) to 0.2% in 2018 and low total fertility rate (1.58 in 2018) (Mahidol University, 2018). It also resulted in an increase in the elderly population (aged 60 and older). Thailand became an ageing society in 2005 with 10.37% (6.7 million) of population age 60 and older (Office of National Economic and Social Development Board, 2007). The ageing population will reach 20% (13.1 million), making Thailand an aged society in 2021, and reach 30% (19.4 million), making the country a super-aged society in 2035 (Office of National Economic and Social Development Board, 2013). In the second period, the ageing population will double within 16 years, and in the third period, it will triple within 14 years (Figure 6.1).

Figure 6.1. Stages of Population Ageing, 2005–2035



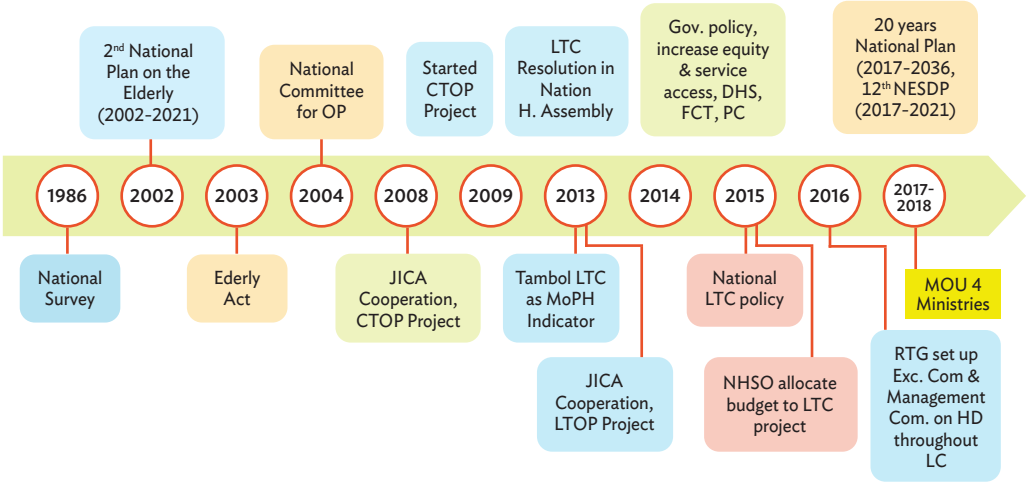
Source: Situation of Thai Elderly 2014, Mahidol Population Gazette 2018.

Long-term Care Policy

Long-term care (LTC) is defined as "a comprehensive care that covers social, health, economic and environmental dimensions for the elderly who undergo hardships due to chronic illnesses, disabilities or infirmities and who are partially able or totally unable to help themselves in their routine daily life. Care can be given formally by health and social workers or informally by family members, friends, and neighbours. Care can also be given in the family setting, community or a service establishment" (National Health Commission Office Thailand, 2009).

The LTC policy did not happen in 1 day. It started in 1986 with the National Survey on Ageing (Figure 6.2). In 2002, the 2nd National Plan on the Elderly (2002–2021) was accepted by the cabinet. It was followed by the Elderly Act 2003 and the establishment of the National Committee on the Elderly (NCE) under the Elderly Act in 2004. The Prime Minister is the chair o the NCE; the minister of Social Development and Human Security and the president of the Older Person Council Association are vice-chairs, representing the government and non-government organisations; and five experts are members of the committee. In 2008, the Ministry of Public Health (MoPH) and the Ministry of Social Development and Human Security (MoSDHS) cooperated with the Japan International Cooperation Agency (JICA) on a project: Community-Based Integrated Services of Health Care and Social Welfare for Thai Older Persons (CTOP). Aiming to develop an LTC model, the project lasted from 2008 to 2012.

Figure 6.2. Long-term Care Policy Development in Thailand, 1986–2018



Note: 4Ministries = ministries of public health, social development and human security, education, and interior; CTOP = community-based-integrated services of health care and social welfare for Thai older persons; DHS = District Health System ; Exc. Com = executive committee ; FCT = family care team ; HD = human development ; JICA = Japan International Cooperation Agency; LC = life course; LTC = long-term care; LTOP = long-term care service development for the frail elderly and other vulnerable people ; MoPH = Ministry of Public Health; National H. Assembly = National Health Assembly ; NESDP = National Economic and Social Development Plan; NHSO = National Health Security Office ; OP = older person; PC = primary care; RTG = Royal Thai Government.

Source: P.Chanprasert, Department of Health, MoPH. Timeline on Long-term Care Development in Thailand, 2018.

In 2009, "Development of a Long-term Care System for Dependent Older People" was proposed as a resolution in the 2nd National Health Assembly and all stakeholders accepted it (National Health Commission Office Thailand, 2009). The 2nd National Plan on the Elderly 2002–2021 was also evaluated and revised in 2009 (Department of Older Persons, Ministry of Social Development and Human Security, 2016). The cabinet approved the revised plan in 2010. The Department of Health (DoH) did the pilot project on community LTC in 2010 and expanded it to 12 regions. Community LTC is an integrated service for the elderly who are dependent (bed-bound) on home care. All health services in community LTC are covered by the Universal Health Coverage Scheme, but social care is provided by family members and volunteers with the support of the local administration, elderly club, and community resources. In 2012, the CTOP project ended and was followed by the Project of Long-term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP), with JICA, which lasted from 2013 to 2017. It was also a model development project. In 2013, LTC was voluntarily implemented at the sub-district level under criteria set by DoH; sub-district LTC was set as an indicator for MoPH implementation and annual inspection.

In 2014, MoH used the LTOP project model to develop a care manager and caregiver training curriculum and started to train care managers (Figure 6.3). The National Health Security Office (NHSO) allocated budget for care manager training in 2014–2015. In 2014, the government declared a policy to reduce social inequity and increase access to government services. In 2015, the community LTC policy was announced as a New Year present for the dependent elderly.

Figure 6.3. Care Manager Training

Source: On 29 May, Certification ceremony was arranged for care manager trainees at Asia Airport Hotel by the Department of Health. (Published on Hfocus on 3 June 2015, available at https://www.hfocus.org/content/2015/06/10097)

In 2016, the government set up an executive committee on life-long human development and a management committee responsible for drafting a 20-year plan for life-long human development.

In 2017, the 20-Year Strategic Plan and Reform (2017–2036) was issued. The LTC policy is under the fourth strategy of the plan: social equality. The 12th National Economic and Social Development Plan (2017–2021) was implemented in accordance with the 20-Year Strategic Plan and Reform. All ministries set up their 20-year and 5-year strategic plans as well as budget plans in accordance with the two strategic national plans. The ministers of public health, of social development and social security, of interior, and of education signed a memorandum of understanding on Human Development Cooperation throughout Life (focus on children and the elderly). The Prime Minister chaired the event (Figure 6.4) and all provincial governors, provincial public health administrators, local administrators, and civil society representatives attended.

Figure 6.4. Prime Minister at the Signing of the Memorandum of Understanding on Human Development Cooperation throughout Life

Source: On 30 March 2017, The Prime Minister at the "Signing of memorandum of understanding on Human Development Cooperation throughout Life (focus on children and the elderly)" between ministers of public health, of social development and social security, of interior, and of education. Picture from gallery of department of older persons, ministry of social development and social security, available at: http://www.dop.go.th › gallery.

In 2018, the government formulated a policy to train quality caregivers and hire them to care for dependent elderly at home and replace elderly care volunteers. The government allocates budget to MoPH to train two caregivers in every sub-district implementing LTC. The local administrations will select caregivers trained by DoH. MoPH will develop the training curriculum, train the trainers, and control the quality of care. The Ministry of Interior through local administrations will manage monthly payment for caregivers and supervise them.

Other policies also support LTC, such as the MoPH policy on the family-care team (multidisciplinary team from a community hospital promoting doctors' visits to the elderly at home); community palliative care (services for those at the end of life, such as cancer patients); district health management system (each district analyses its own health problems, prioritises problems, solves problems through the district health committee); and training of family doctors to work in community hospitals. NHSO allocates funds to train care managers in community

LTC programmes and community health promotion. The Ministry of Social Development and Human Security (MoSDHS) and the Ministry of Interior (MoI) fund home improvement for the poor elderly. MoSDHS builds quality-of-life development centres for the elderly in every district. They promote health, income-generating activities, and rehabilitation for semi-dependent and dependent elderly. The Ministry of Education through the Department of Informal Education supports community caregiver training.

Long-term Care System and Services

The LTC programme is not institution based. It focuses on community-based and home care services. The community LTC system will be discussed at several levels (Figure 6.5). The central administration (ministry) level provides policy and law, develops standards and training for trainers. Regional and provincial public health offices train care managers and caregivers, and monitor, supervise, and evaluate the programme. Provincial, district, and sub-district hospitals are under the provincial public health administration. Provincial and regional hospitals provide tertiary and specialisation care. The provincial public health office supports, promotes, monitors, and controls standards; evaluates provincial, district, and sub-district projects; and cooperates with related agencies. District community hospitals provide secondary care. Sub-district hospitals and community health centres provide primary care. Every sub-district that implements community LTC has to survey the elderly and assess their activities of daily living by using the assessment form based on the Barthel Index standard, and classify the elderly into three groups to serve as baseline data for LTC planning. A family care team (physician, nurse [care manager], physiotherapist, nutritionist, pharmacist, elderly care volunteer, village health volunteer, etc.) from a community/district hospital, sub-district health-promoting hospital and local administration visit the dependent elderly at home and provide home health care and rehabilitation. Caregivers provide social care and rehabilitation. Family volunteers or family caregivers are important in caring for dependent elderly at home. They are also listed as

caregiver trainees and are supervised by a care manager and family care team.

Long-term Care Implementation

To implement LTC, the government developed a model with JICA under the CTOP project. In 2011, DoH started developing criteria to implement a pilot project on sub-district and community LTC in 12 regions in 2011:

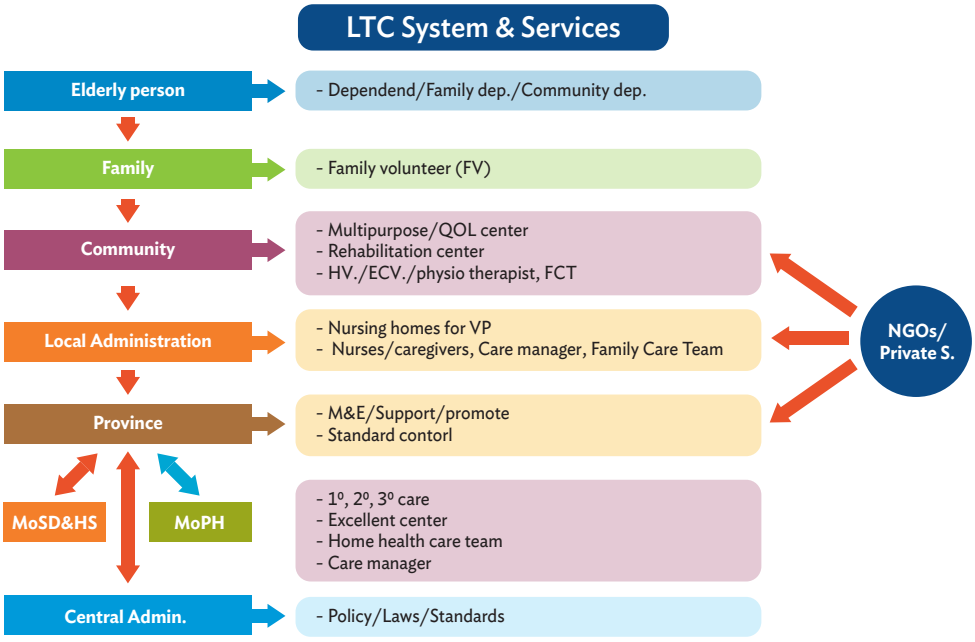
1. having elderly data and classifying the elderly into three groups according to activities of daily living: the independent or socially bound group, the semi-dependent or homebound group, and the dependent or bed-bound group);

2. having quality home health care system;

3. having elderly care volunteers and health volunteers to care for the dependent elderly;

4. having quality elderly clubs;

Figure 6.5. Long-term Care System and Services



Note: LTC = long-term care; dep = dependence; QOL = quality of life; HV = health volunteer; ECV = elderly care volunteer; FCT = family care team; VP = vulnerable people; MoSD = Ministry of Social Development and Human Security; MoPH = Ministry of Public Health; 1o= primary; 2o = secondary; 3o = tertiary, NGO = non-government organisation; Private S = private sector
Source: Chanprasert,P. and Piensriwatchara.E., presented at the WHO Regional Consultation on Long-term Care held in Bangkok, Thailand during 22-25 July 2013..

5. promoting oral health for the elderly; and

6. setting up an integrated community care system for the dependent elderly.

The LTC policy and criteria for implementation were communicated to the provincial, district, and sub-district levels through central administration meetings and provincial health board meetings. Sub-district and community LTC was implemented on a voluntary basis. The LTOP project with JICA was continued in 2013 after the CTOP project ended. DoH developed care manager and caregiver training curriculums and trained the trainers. NHSO and DoH visited community LTC services and assessed them. NHSO allocated budget to DoH to manage training. DoH trains the trainers for care managers of each province and Metropolitan Bangkok. The provincial trainers train care managers and caregivers at the district and sub-district levels, with support from regional health centres, nursing colleges, and informal education centres.

LTC is implemented in sub-districts as integrated care through district and sub-district health committees. Family care teams visit dependent elderly at home. After the first visit, the care manager and caregivers draw up a care plan and use it to provide care at home. Caregivers report cases to the care manager and, if consultation is needed, may consult the care manager on the telephone or through LINE communication. Rehabilitation may be done at home or at rehabilitation, multipurpose, and quality-of-life development centres, depending on the condition of the elderly, the care plan, and the community management system.

Figure 6.6. Elderly Undergoing Rehabilitation at a Community Centre

Source: On 11 April 2015 Minister of Public Health visited Day Care Services at Bangsithong rehabilitation center for older persons, Nonthaburi, under the Long-Term Care Project. (Published on Hfocus on 16 April 2016, available at https://www.hfocus.org/content/2016/04/12029)

Local administration is important in supporting community LTC. For example, local administration personnel join family care teams to visit dependent elderly at home; act as care managers; provide devices for semi-dependent or dependent elderly to use at home; provide budget to build community rehabilitation, multipurpose, and quality-of-life development centres; and repair homes or renovate toilets for the poor elderly. Some local administrations have residential homes for the vulnerable elderly. Regional inspectors and health personnel from provincial public health offices and regional health centres monitor and supervise sub-district and community LTC through the MoPH inspection system. DoH developed a programme to register care managers and caregivers and an LTC report system through the Health Data Centre.

Recognition and knowledge management are key to the programme's success. Rewards are given for best practice at annual meetings to exchange experiences on sub-district LTC with all stakeholders.

In 2018, 161,931 older persons in 4,795 sub-districts (66%) received LTC services; 12,817 care managers and 74,833 caregivers were trained. Older persons improved their functional abilities thanks to the programme.

Figure 6.7. Sub-District Long-term Care Awards for Best Practice

Source: On 6 July 2016, The Department of Health, MoPH gave awards to sub-district administrations and health personnel for their best practices on long-term care in Health Region 1 at Chiang Mai province.

Changes

MoPH plans to achieve 100% sub-district LTC in the next few years and develop quality caregivers in every sub-district. The ministry will link LTC data and reports with NHSO's data system and local administration to pay and retrain care managers and caregivers. Working with JICA, the ministry will also develop intermediate care model for the better care for the elderly.

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CHAPTER 7

Older Persons and Long-term Care in Viet Nam

Phan Hong Van, Khuong Anh Tuan, and Tran Thi Mai Oanh

Introduction

ThailViet Nam's population in 2017 was 93.7 million, with 64.9% living in rural areas (GSO, 2016a). The proportion of the population over the age of 60 reached 10% in 2011. Currently, 11.6% are over 60; that number will rise to 16.7% in 2029 and 21.37% in 2039 (GSO (1979, 1989, 1999, 2008); UNFPA, 2011).

Viet Nam is reforming its policies and systems to respond to a changing context. A long-term care (LTC) system for the elderly is still a new concept in Viet Nam. Long-term health care, social care, and elder care are understood differently by various stakeholders. This report aims to identify the characteristics of population ageing, care needs of older people, policy issues, long-term care models, and gaps and recommendations.

Methods

We used desk study, review of literature on ageing population and existing policies, models related to long-term care for older persons in Viet Nam, and secondary data analysis from data sets of national surveys (Vietnam Women's Union, 2012; GSO and UNFPA, 2016a; GSO, 2016a).

Main Findings

1. Characteristics of population ageing

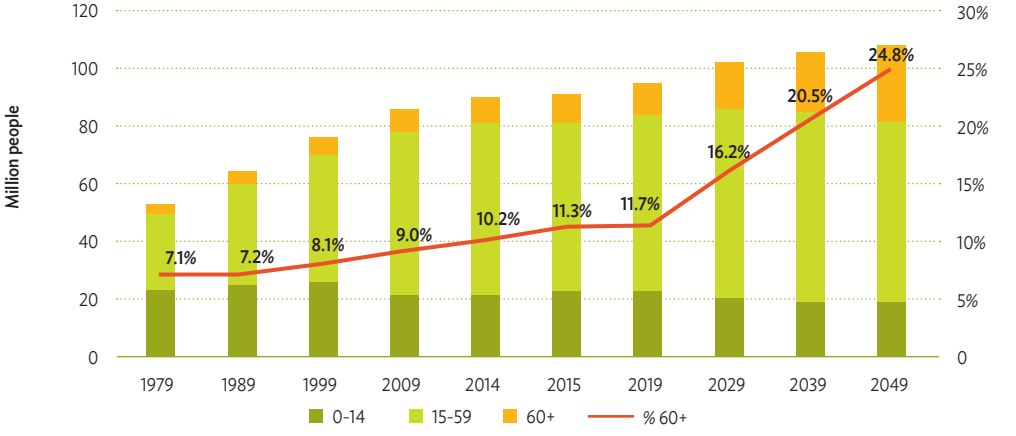
Viet Nam is one of the fastest ageing countries in the world

If 'ageing speed' is defined as the duration from the year when the percentage of older people aged 65 years or above reaches 7% to the year when this percentage reached 14%, Viet Nam's ageing speed will be only 27 years (2011–2037), similar to China – 27 years (2000–2027) and Japan – 26 years (1970–1996), and much faster than developed countries such as France – 115 years (1865–1980), Sweden – 85 years (1890–1975), Australia – 73 years (1938–2012), and the United States – 68 years (1944–2012) (Kinsella and Gist, 1995).

The proportion of elderly people has increased rapidly. Ageing occurs most rapidly in the oldest age group (80+)

In the past 35 years, Viet Nam's population has changed tremendously in size and age structure: the proportion of elderly has increased rapidly, with those aged 60 and over accounting for 6.9% in 1979 and 11.3% by 2015. Since 2012, Viet Nam has been aged, as those 60 and over made up 10.2% of the total population (GSO, 2012) and it will become very aged in 2038, when they make up 20.1% (GSO and UNFPA, 2016b). By 2049, older persons are estimated to account for about 25% (Figure 7.1).

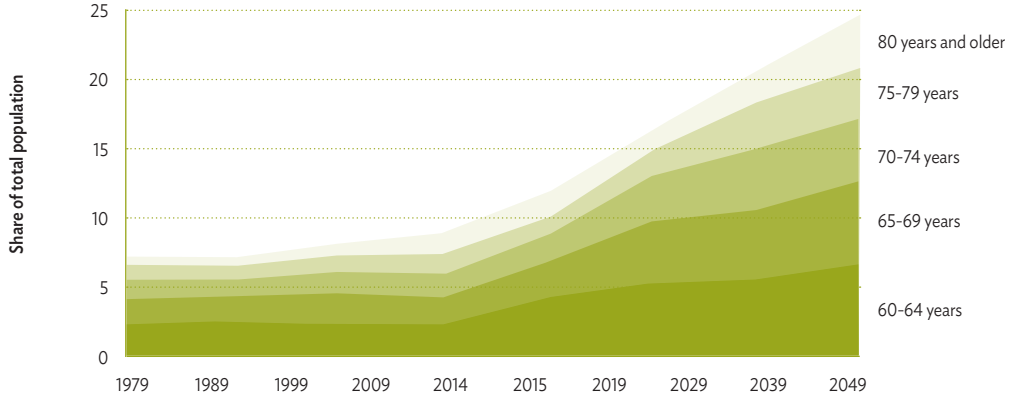
Figure 7.1. Viet Nam's Age Structure and the Proportion of Population Aged 60 and Older, 1979–2049



Source: GSO (1979, 1989, 1999, 2009); GSO (2016b); GSO (2016a); Viet Nam Ministry of Health – Health Partnership Group (2018).

The oldest group is increasing most rapidly: those aged 80 and over increased from 0.33 million (9% of the total elderly population aged 60 year or above in 1979 to 1.95 million in 2015 (18.8%) and are forecast to reach 4.3 million (15.9% of the total elderly population) by 2049 (GSO and UNFPA, 2016b) (Figure 7.2).

Figure 7.2. Age Structure Trends Amongst Older Age Groups, 1979–2049

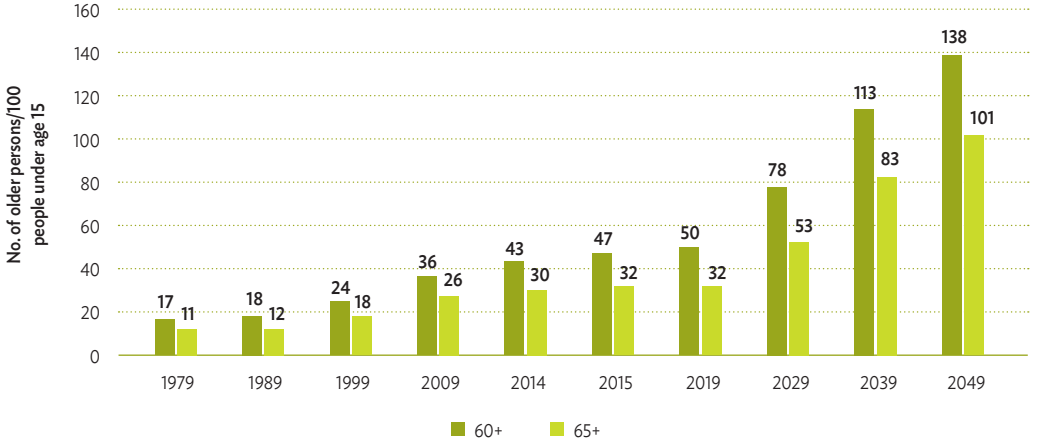


Source: GSO (1979, 1989, 1999, 2009); GSO and UNFPA (2016b).

The ageing index is increasing quickly, and the aged dependency ratio is increasing

The ageing index increased 2.8 times in 1979–2015, from 17 to 47 (Figure 7.3). By 2049, the ageing index will increase to 138, meaning there will be 138 persons aged 60 or over per hundred children aged under 15.

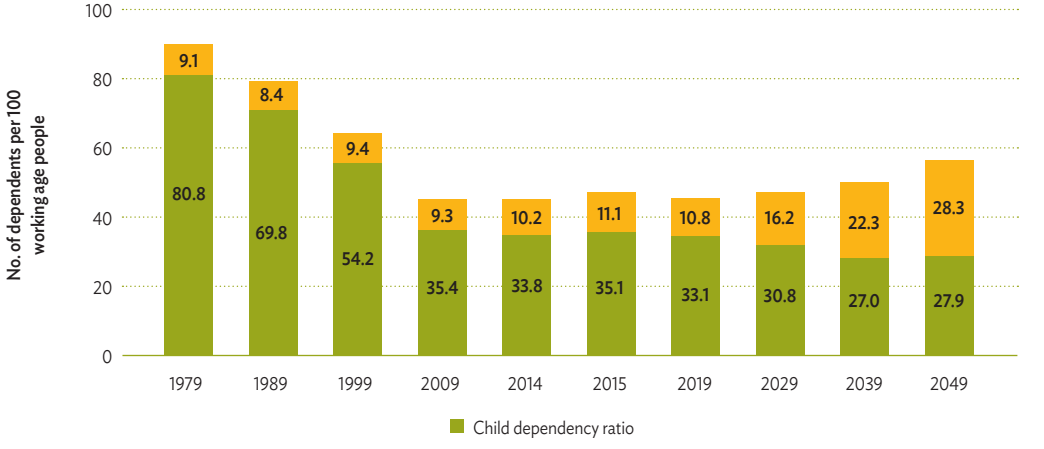
Figure 7.3. Ageing Index, 1979–2049



Sources: Viet Nam Ministry of Health (2018). GSO (1979, 1989, 1999, 2009); GSO (2015); GSO (2016a); GSO and UNFPA (2016b); Viet Nam Ministry of Health – Health Partnership Group (2018).

The recent rapid increase of the ageing index is mainly due to the decrease of the child dependency ratio. In 1979–2009, the aged dependency ratio remained stable at around 1 older person per 10 working-age people. However, it was 1 older person for every 9 working-age people in 2015, and is forecast to increase sharply in to 1 older person for every 6.2 working-age people in 2029 and 1 older person for every 3.5 working-age people in 2049 (Figure 7.4).

Figure 7.4. Dependency Ratio, 1979–2049



Source: Viet Nam Ministry of Health (2018).

Feminisation of ageing and increase in widowhood and older persons living alone

The proportion of females in the ageing population is increasing. In 2014, for every 100 women there were 79 men aged 60–69, 63 aged 70–79, and only 52 aged 80 and older (Table 7.1). By 2049, the number of men per 100 women is estimated to increase significantly in all age groups (Pham and Do, 2009).

Table 7.1. Sex Ratio By Age Group Amongst Older Persons, 1979–2049

Age group	Sex ratio (male/100 females)						
	1979	1989	1999	2009	2014	2029	2049
60–64	81.6	82.9	78.3	80.1	79.6	92.5	95.9
65–69	74.8	76.6	80.6	72.5	79.1	87.3	91.4
70–74	65.4	67.8	71.5	67.3	69.6	79.6	86.1
75–79	58.5	59.6	60.3	66.8	63.0	70.5	80.3
80+	45.8	46.9	48.3	49.9	52.1	48.5	63.2
60+	94.2	94.7	96.7	97.7	97.3	81.2	84.8

Source: GSO (1979); GSO and UNFPA (2016b). 1979–2014 data from GSO and UNFPA (2016b). 2015 data from GSO (2015). 2019–2049 projections from GSO and UNFPA (2016b).

The proportion of widows to widowers amongst the elderly 60+ is 36.1%. With increasing age, the proportion of widows to widowers is higher (19.4% aged 60–69 and 62% aged 80+) (Table 7.2).

Table 7.2. Marital Status of the Elderly (% by population)

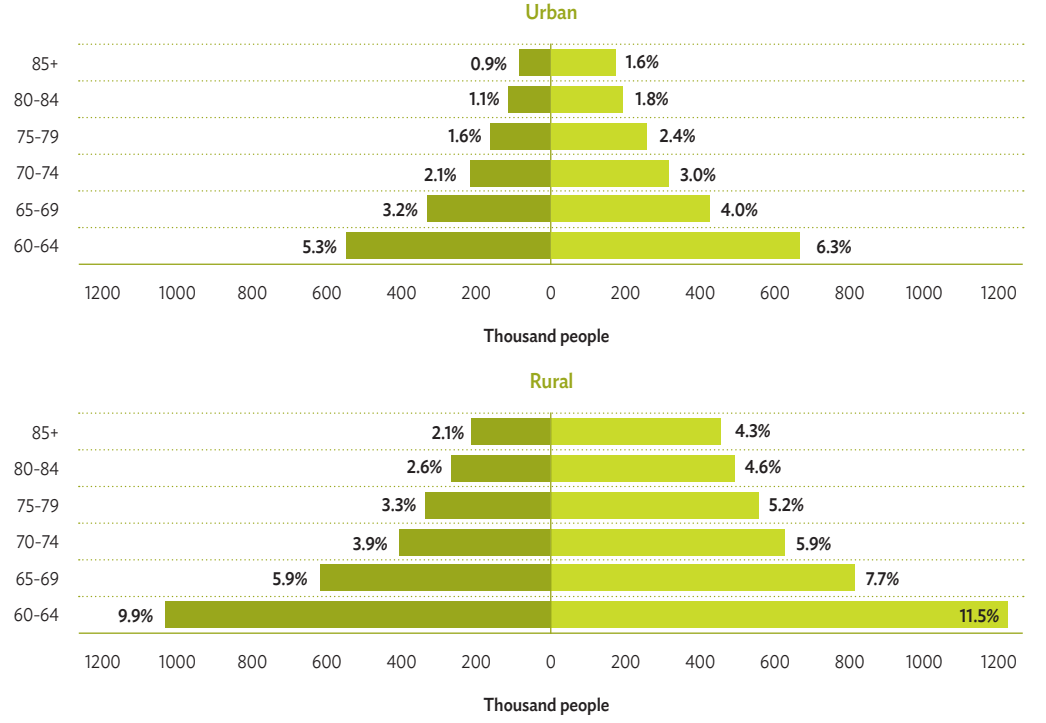
	Sex ratio (male/100 females)				Sex	
	60+	60–69	70–79	80+	Male	Female
Single	3.7	5.6	3.3	0.4	1.2	5.4
Married	58.9	72.7	54.9	37.1	84.3	42.1
Divorced	0.8	1.5	0.2	0.1	0.2	1.1
Separated	0.5	0.7	0.4	0.5	0.4	0.6
Widow to Widower	36.1	19.4	41.2	62.0	14.0	50.7
Total	100	100	100	100	100	100

Source: Vietnam Women's Union (2012).

Older persons mainly live in rural areas and this tendency increases with age

In 2015, about two-thirds of the elderly lived in rural areas. People aged 60–64 in urban areas accounted for 11.6% of the total elderly population whilst those in rural areas accounted for 21.4%, which means this age group accounts for 33% of the total elderly population (Figure 7.5). The next age group accounted for approximately 20% of the total elderly population. The number of older people falls by half between the 60–64 and the 70–74 age groups, likewise between the 70–74 and the 85 and older age groups. Thus, the 85 and older age group accounts for only 8.9% of the total elderly population. Whilst 35% of the 60–64 age group lives in urban areas, the figure for the 85 and older age group is only 28%.

Figure 7.5. Population Pyramid for Older Persons by Urban or Rural Residence, 2015



Source: Viet Nam Ministry of Health (2018).

The proportion of older persons living alone or living with their spouse is increasing

The proportion of older persons living with children was significantly reduced (80% in 1993 [UNFPA, 2011] and 69.5% in 2011 [Vietnam Women's Union, 2012]). The proportion of older persons living alone increased to 6.2% in 2011 and of those living with their spouse to 13.8% in 2011 (Table 7.3).

Table 7.3. Elderly People Living with Family Members and Others (% by population)

Living with	Total	Age group			Sex		Area	
		60–69	70–79	80+	Male	Female	Urban	Rural
Alone	6.2	6.0	10.6	14.3	2.0	9.3	3.4	7.6
Husband/Wife	13.8	16.8	16.2	10.7	17.8	10.9	9.7	15.9
Children	69.5	63.8	63.9	67.6	72.0	67.7	78.0	65.3
Grandchildren	5.9	8.5	6.6	6.5	4.4	7.0	5.1	6.3
Others	4.6	4.9	2.8	0.8	3.8	5.2	3.9	4.9
Total	100	100	100	100	100	100	100	100

Source: Vietnam Women's Union, 2012.

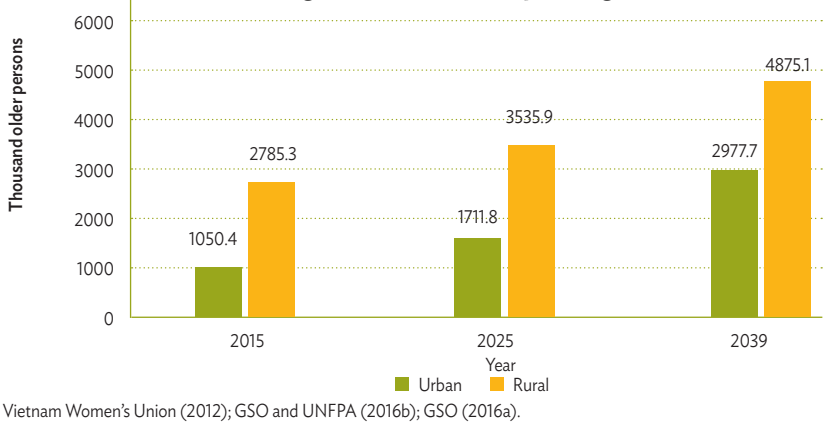
The percentage of older persons living with only grandchildren (but without children) is increasing: 7.1% in 2011 (Vietnam Women's Union, 2012). This can be explained by the impact of rural-to-urban migration of young people (second generation).

2. Care Needs of Older Persons

Older persons with difficulty in activities of daily living

The proportion of older persons with at least one difficulty in activities of daily living is 37.6% (Vietnam Women's Union, 2012). In 2015, nearly 4 million older persons had at least one difficulty in activities of daily living; that number is estimated to increase rapidly to about 5 million in 2025 and about 8 million in 2039 (Figure 7.6).

Figure 7.6. Projected Number of Older Persons with Difficulty in Performing Activities of Daily Living, 2015–2039

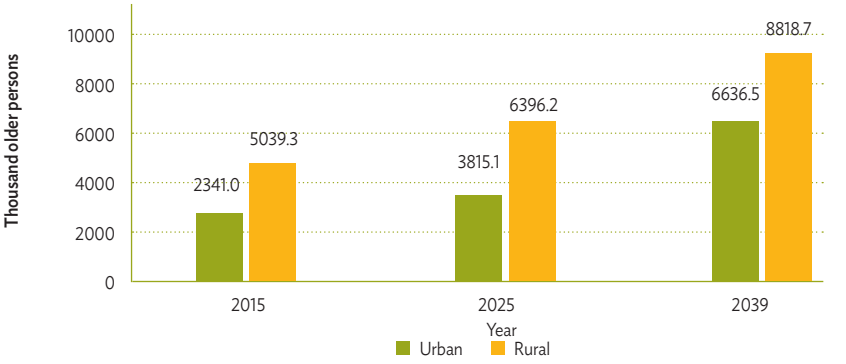


Source: Vietnam Women's Union (2012); GSO and UNFPA (2016b); GSO (2016a).

Older persons with difficulties moving

The proportion of older persons with at least one motor difficulty is 71.6%. In 2015, 7.4 million older persons needed LTC; that number is estimated to be about 10 million in 2025 and more than 15 million in 2039 (Figure 7.7).

Figure 7.7. Projected Number of Older Persons with Having at Least One Motor Difficulty, 2015–2039

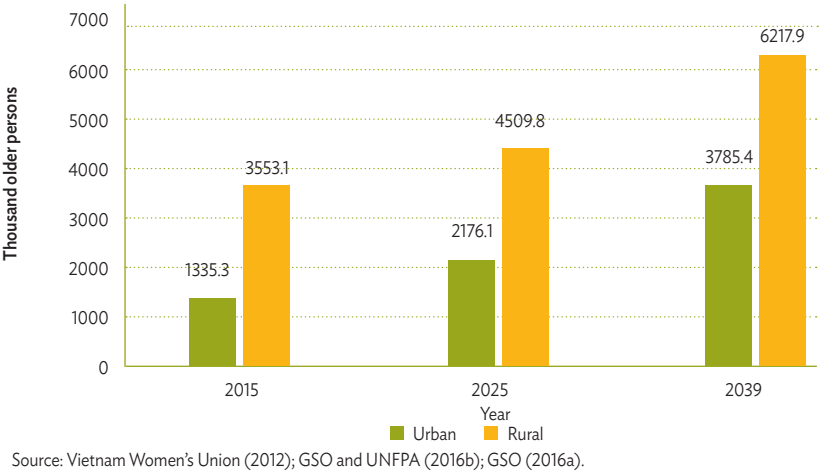


Source: Vietnam Women's Union (2012); GSO and UNFPA (2016b); GSO (2016a).

Older persons with very bad or bad memory

The proportion of older persons with very bad or bad memory is 48% (Vietnam Women's Union, 2012). In 2015, nearly 5 million needed LTC; that number is estimated to be nearly 7 million in 2025 and about 10 million in 2039 (Figure 7.8).

Figure 7.8. Projected Number of Older Persons with Very Bad or Bad Memory, 2015–2039



Source: Vietnam Women's Union (2012); GSO and UNFPA (2016b); GSO (2016a).

Although many older persons needed LTC in 2011, only 36% received help when they had difficulties with their activities of daily living (Vietnam Women's Union, 2012). The proportion of older persons who will not receive any support for difficulties in activities of daily living is estimated to remain high (27%). The LTC supply system needs to be improved.

3. Policy related to long-term care

General laws and health policies related to the elderly

Policies related to the elderly have been enacted, including those on health care for the general population and for the elderly. These policies emphasise the role of primary health care and health care services for the elderly, increasing access to quality healthcare services.

The government has social support and free health insurance cards for those 80 and older and for the vulnerable elderly (without caregivers, disabled, the poor). The government subsidises nearly 70% of the health insurance premiums for the near poor, including the elderly poor.

These policies also emphasise the role and responsibility of families, communities, and the whole society in caring for the elderly.

Specific laws and policies for the elderly

As it considers the elderly a priority group, the government has issued many policies to support them. The Elderly Law (2009) defines the rights and obligations of the elderly; the responsibility of the family, government, and society in supporting, caring for, and promoting the role of the elderly; and the organisational structure of the Viet Nam Elderly Association. The law also mentions the responsibility of the government to ensure subsidies and health insurance for those over 80 and for the vulnerable elderly (those without a caregiver, with disabilities, the poor); of the family and the whole of society to care for the elderly; and of the Ministry of Health to provide healthcare services to the elderly. The law emphasises establishing nursing homes for the elderly.

Policies on healthcare for the elderly include the National Agenda for the Elderly in 2012–2020 (Decision 1781 / QD-TTg). A Ministry of Finance circular prescribes the management and use of primary healthcare for elderly people in residential areas. A Ministry of Health circular provides for healthcare for the elderly in healthcare facilities and communities and for management of chronic diseases.

Policies to improve the availability and quality of healthcare services at the grassroots level

The government has also issued many policies to promote primary healthcare and healthcare at the grassroots level. These policies cover all aspects of healthcare, including strengthening organisational structures, human resources, pharmaceuticals, health financing, and healthcare delivery.

Policy on training in medical schools, geriatric training: *Gaps in policy content*

The healthcare policies for the elderly are generally comprehensive, but most are difficult to implement due to lack of funding and incentives and because penalties do not often result in effective implementation.

The following are also lacking:

- multisectoral coordination to ensure that all stakeholders are involved in policy implementation;
- monitoring and evaluation of policy implementation, resulting in limited policy effectiveness;
- attention to LTC and LTC policies; and
- human resources to provide LTC.

Viet Nam needs national medium- and long-term policies to build an LTC system.

4. Long-term care models

Most elderly care services are provided primarily by family members who are largely uneducated or supported by outsiders. Family-based care is increasingly decreasing and insufficient. Some people with complex care needs require support beyond what family members can provide.

No criteria regulate the formal care services although many people can afford them. High-quality services are available in some areas. The Ministry of Health and Ministry of Labour, Invalids, and Social Affairs has programmes that provide elements of LTC. Mass organisations and the private sector also provide LTC. However, there is no comprehensive LTC-based model or national integration of different services with a long-term perspective on human-centred care.

LTC service provision mainly supports family care provision with home-based services and residential homecare. The Intergenerational Self-Help Club model, which includes a multisectoral approach to community development, including health promotion and prevention activities, promotes volunteer-based home care. Paid home care is emerging as key for supporting older people without the means to pay for private care (Ministry of Health, 2016). Residential care is important for a small minority of people who cannot be safely or adequately cared for at home. Table 7.4 summarises key long-term care models.

Table 7.4. Care Models for the Elderly

Models	Care receivers	Caregivers	Services
1. Community and family-based model			
1. Home-based care provided by volunteers Started in 2003 through a regional project: Korea–ASEAN cooperation on home care for disadvantaged elderly people relying on volunteers. It was implemented with support from HelpAge Korea and with technical assistance from HelpAge International, and in collaboration with The Research Centre for Ageing Supportunder the Viet Nam Red Cross.	Elderly with difficulties in activities of daily living	Trained volunteers (>1700 volunteers)	Healthcare, help with activities of daily living (personal care)
2. Intergenerational self- care club Started in 2006 as part of a project by HelpAge International, with technical assistance and funding from international organisations (HelpAge, European Union, Korea International Cooperation Agency, UNFPA, Atlantic Philanthropies, UK Lottery).	Elderly	Engaged by people of many age groups, 60%–70% are elderly	Improvement of income Socio-cultural activities Healthcare and home and community care support
3. Counselling club and healthcare model for the elderly In 2011, the General Office of Population and Family Planning under the Ministry of Health conducted counselling and caring for older people in the community to improve their physical and mental health and quality of life, and to promote their role in society.	Elderly	Volunteers, Commune health station staff	Counseling and healthcare Socio-cultural activities, sports Support for the Association of the Elderly
2. Institutional care			
1. Social protection centres (13 belong to Ministry of Health and Ministry of Labour, Invalids, and Social Affairs)	Many groups, including the elderly	Health and social staff being trained	Basic daily and healthcare services
2. Private care centres for the elderly	The elderly with decreasing ability to perform activities of daily living, instrumental activities of daily living; and can afford to pay for services	Social staff, nurses being trained with technical support from public health facilities	Integrated care, close to long-term care

Gaps in long-term care models

- Primarily based on family; no consistent LTC training programme
- Nursing homes mostly located in big cities, mainly afforded by the better off
- Limited number of social protection centres, which do not meet all needs, operate inefficiently
- Based on household out-of-pocket payment; limited government budget and health insurance

Recommendations

(1) Develop an LTC system, including principles, values, and objectives.
(2) Take a rights-based approach and base LTC on active ageing and healthy ageing frameworks.

(3) Increase awareness of the need for LTC services and related issues amongst a wide range of stakeholders, including national and local authorities, older persons and their families, private sector mass organisations.
(4) Because LTC services are multidisciplinary, identify a high-level focal point to ensure coordination amongst stakeholders involved in developing LTC services.
(5) Build the LTC system on existing systems and programmes and utilise existing resources in the most efficient way possible. Implement existing policies and programmes adequately as these will support LTC development.

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CHAPTER 8

Conclusions

Osuke Komazawa and Yasuhiko Saito

The first part of this book provides a comprehensive view of long-term care systems in selected Asian countries. A look at each reveals distinct characteristics of their population dynamics and the development of their long-term care systems. China has the largest population in the world and the greatest number of people aged 65 years and above. The current rapid population ageing observed in China can be partly attributed to its recently ended unique population policy. Japan has the highest proportion of people aged 65 years and above to the total population and has developed a unique long-term care insurance system. The Republic of Korea is characterised by extremely rapid population ageing, which is accelerated by one of the lowest fertility rates in the world. The Republic of Korea has also developed a long-term care insurance system. Singapore is a city state, has one of the highest incomes per capita, and is highly dependent on overseas caregivers for its rapidly growing population of older people. Thailand, with its steadily rising life expectancy and low fertility rate, is demonstrating exceedingly rapid population ageing, as well. Thailand is trying to establish a long-term care system combining intrinsic mutual aid within communities and public intervention. Thailand's system is different from tax revenue–based systems, such as can be found in Nordic countries, and insurance-based systems in countries such as Japan and the Republic of Korea. Viet Nam is on the alert to prepare for population ageing, as it will occur before the country becomes wealthy enough to cope with it. Population ageing in Viet Nam presents a new and different challenge because, to date, population ageing has been experienced largely in developed countries.

In this chapter, we recommend policies based on the discussion in the previous chapters and on the projects the Economic Research Institute for ASEAN and East Asia (ERIA) supports.

Longer Healthy Life Expectancy

Humanity has achieved longevity partially owing to public health and medical science. It is ironic that whilst birth control has been or was the goal of population control policies in most countries, some are now struggling to increase fertility. One could argue that population ageing is an indication of the success countries have had in improving longevity and controlling population growth. Now, we need to find ways to cope with the resulting issues of population ageing.

One such issue is the potential surge in the number of older adults with diseases, particularly co-morbid conditions. If the prevalence rate of chronic and non-communicable diseases stays constant during population ageing, we can expect an increase in the number of older adults with chronic and non-communicable diseases such as cerebrovascular-related illnesses, diabetes mellitus, and hypertension, as well as mental disorders such as depression and dementia. This, in turn, will increase the burden of disease in terms of medical expenditures and long-term care needs. Preventing and delaying the onset of disease are key to reducing its burden. We must develop policies to promote health and active ageing so that the burden of population ageing can be minimised and more older persons can participate in social activities that maintain their quality of life.

A reliable and well-structured database is indispensable to develop evidence-based policies that promote health and active ageing. A national census is, no doubt, the basis of any policymaking process. Nationally representative sample surveys, such as the National Health Survey, the Survey of Living Conditions, or the National Patient Survey, can provide rich information. ERIA has started joint projects with research institutions in the Philippines and Viet Nam to conduct longitudinal surveys of persons 60 years old or above, because no such surveys have yet been implemented in the two countries. Other countries discussed in this volume have similar ongoing surveys. A longitudinal survey is the only method that can establish cause and effect. With data from a longitudinal survey, potential determinants of health and mortality can be identified. This means that the outcomes of longitudinal surveys can be directly utilised to develop policies to promote health and active ageing. The data can be used to estimate health expectancy, a summary measure of population health, to monitor the health status of older adults. The data provide an opportunity to estimate life expectancies by variables of interest (e.g. education and body mass index), which are not readily available in these countries. The quantified effects of determinants of health status such as number of healthy years expected after age 60 or differences in number of years expected after the same age by level of education are more appealing and visible to policymakers and laypeople alike.

ERIA can only guarantee limited waves of longitudinal surveys in the Philippines and Viet Nam, but we hope their governments will take over the surveys. We also hope governments of other Association of Southeast Asian Nations (ASEAN) Member States will be involved in such surveys. Indeed, longitudinal surveys are recommended by the Global Strategy and Action Plan on Ageing and Health published by the World Health Organization in 2017.

Establishment of Long-term Care Systems

Even if policies on health promotion and active ageing are successful, societies might still face a certain proportion of older persons with long-term care needs. Whilst we are increasingly able to save the lives of older adults with heart and cerebrovascular diseases, for example, we are not able to cure them despite tremendous advancements in medical technology. ERIA has a joint study project that estimates the proportion of older people with long-term care needs in the total population. The results, combined with population projections published by the United Nations (UN), are used to estimate the future number of older people with long-term care needs. It is expected that a tremendous number and proportion of people in Asia will need long-term

care even just a couple of decades from now (Hayashi, 2019). The development of long-term care systems is urgent, particularly in ASEAN countries, where rapid population ageing is expected. Many ASEAN countries still rely on family-based social norms of filial piety to care for older adults with long-term care needs. However, ASEAN countries are encouraged to promote discussion on whether such a system might work forever or not and how to establish a policy to create reliable long-term care systems. Each ASEAN country, constrained by limited resources, has its own policy priorities for its people, but postponing the establishment of population policies is clearly no longer an option.

In previous chapters, we see that long-term care systems are varied because they are closely related to each society's tradition, history, culture, and norms. If we look at long-term care systems all over the world, they may be categorised based on the financial resources used to provide long-term care and the extent of income redistribution in each country. Nordic countries, where levels of taxation and income redistribution are the highest, rely almost solely on tax revenues to provide long-term care. Countries such as Germany, Japan, and the Republic of Korea fund their long-term care insurance through tax revenues and premiums. Theirs are compulsory insurance systems, so all residents must pay the premiums. China, as Yun Zhou and Dandan Pang show in chapter 2, has pilot programs of long-term care insurance in place in several big cities. Countries with either tax revenue–based or insurance-based long-term care systems have strong fundamentals that allow providing universal long-term care to beneficiaries. Unfortunately, most countries do not have such systems.

Countries that do not have well-structured long-term care systems largely depend on filial piety and traditional community mutual aid. In countries where more traditional norms prevail, most of the care is provided either as unpaid work by (extended) families and communities. The income gap is key to understanding the long-term care system of such societies, where older people with higher incomes are often cared for by domestic workers, who mainly come from underprivileged backgrounds and, in many cases, from other lower-income countries. Any type of long-term care system has merits and demerits. Policymakers are expected to review the lessons from several long-term care system models and develop their own long-term care systems consistent with the realities of their society.

Population ageing is an indication of humanity's success in improving longevity and reducing fertility. The ageing phenomenon, observed in the end stage of demographic transitions, may last many years. There are several indicators of population ageing. According to the long-range population projections published by the UN, Department of Economic and Social Affairs, Population Division (2019), if we use the proportion of those aged 65 and above to total population as an indicator of population ageing, the proportion will keep increasing well over to the next century in many countries. Some Asian countries, however, might see reverse trends in population ageing within this century. The proportion will peak in about 2060 in Japan and the Republic of Korea, 2070 in Singapore, and 2090 in Thailand. Likely to see reverse trends in population ageing are certain European countries, such as Spain in about 2050 and Italy in about 2080. We need to pay closer attention to the increase in the proportion of those aged 75, 80, or 85 and over. They have a much higher risk of becoming disabled, demented, and in need of long-term care. The proportion of this group will keep increasing everywhere for a long

time. It is imperative, therefore, that we find a way to keep older adults healthy and active. We must develop systems to support those needing long-term care before it is too late to ensure their quality of life. Advancements in gerontechnology might make it easier to care for older adults needing long-term care. Advancements in medical technology, such as regenerative medicine, might alter the course of population ageing. Alternatively, the UN (2019) projected population change might not happen after all. Nevertheless, it would be wise to prepare for such projections. For many countries, the time to prepare is now, not later.

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PART 2:

Care Workers Migration in Ageing Asia

CHAPTER 1

Care Workers Migration in Ageing Asia

Wako Asato

Ageing has become one of the most important social concerns not only in developed but also in developing Asia. Lower morbidity and mortality; greater longevity; and changing lifestyles, particularly lower fertility, have increased the proportion of older people more than of any other age cohort. Other social factors such as higher labour participation rates for women; higher mobility brought about by urbanisation, which lowered three-generation cohabitation ratios; and the nuclearisation of families has made it difficult to provide sufficient care within traditional households or within communities. The epidemiological turn has also made providing care more difficult: dementia is as serious as cancer, paralysis, and cardiovascular disease.

Demographic change, mobility, changing families, and an epidemiological turn have given rise to the social challenge of ageing. Difficulty in securing care has triggered a big international movement of many levels of care providers: nurses, care workers, and domestic workers, who are labour migrants; and even marriage migrants, who are non-labour, personal migrants, whose movement is commercialised through match-making agencies.

Migration has been feminised, since most of the workers are women. The huge need for care results from the change of some countries from care-abundant to rapidly ageing societies.

The proportion of older people who are 65 years old or above to the total population was 27.7% in 2017 in Japan (Cabinet Office, Government of Japan, 2018), 15.2% (the denominator is 'Singapore Residents') or 10.8% (the denominator is 'Total Population') in 2020 in Singapore (Department Statistics Singapore, 2020), 18.3% in 2020 in Hong Kong (Census and Statistics Department, Hong Kong SAR, 2020a), and 15.3% in 2019 in Taiwan (National Statistics, Republic of China (Taiwan), 2020). Asian countries are familialistic welfare regimes, where the family is the core provider of care. Care for older people, however, varies across Asia. Japan earmarks more than 20% of gross domestic product for social expenditure but Singapore allots less than that, which does not necessarily mean they have different proportions of care-dependent people but does indicate differences in long-term care policies.

Singapore and Hong Kong have typical familialistic welfare system, where families are crucial in providing long-term care and are encouraged by the governments to do so. As they age, all societies present family care providers with challenges. The rapidly increasing proportion of older people and the increasing number of care-dependent older people create a supply–

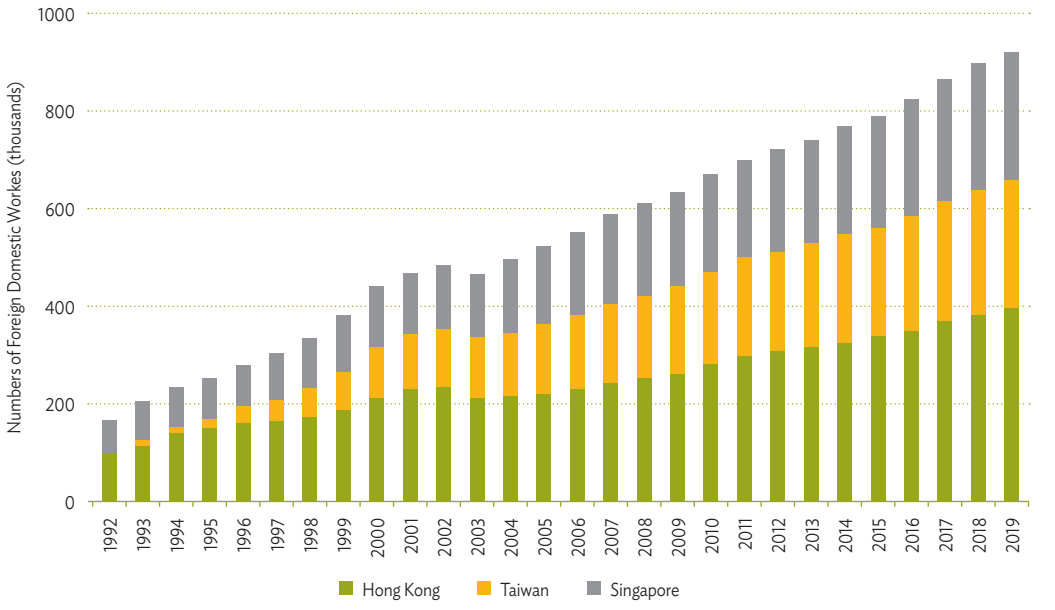
demand gap in long-term care. Rapid economic development has increased female participation in the labour force (whilst leaving the gender division of labour unchanged) and eroded the family's capacity to care for older people at home. Such societies employ a huge number of foreign domestic helpers (FDHs) or foreign domestic workers (FDWs) to supplement family care.

Japan started the Gold Plan in 1989, the New Gold Plan in 1995, and long-term care insurance in 2000, giving the state the major role in providing long-term care. Taiwan and the Republic of Korea (henceforth, Korea) are in between Singapore and Hong Kong and Japan. Korea started long-term care insurance in 2008, and Taiwan launched a 10-year long-term care plan in 2008 and expected to launch long-term care insurance afterwards. The plan was postponed, however, due to the change in government from the Kuomintang to the Democratic Progressive Party, which started a tax-based community care system instead of an insurance system.

Familialism in Asia

Familialistic welfare regimes have a long history of recruiting migrant domestic workers to care for older people. Singapore and Hong Kong started in the 1970s, whilst Taiwan, which had a bigger labour force, opened the labour market to foreigners in the 1990s (Asato, 2010, 2014) . The number of domestic workers has never declined, except in 2003, during the SARS outbreak (Figure 1.1). The constant increase in care workers reflects the constant increase in care demand. The dependency on migrant domestic workers intensifies the familialistic care regime whilst externalising direct care.

Figure 1.1. Numbers of Foreign Domestic Workers, 1992–2019



Source: (Hong Kong) Census and Statistics Department, Hong Kong SAR, 2020b, 2014, and 2008
(Taiwan) Ministry of Labor Republic of Taiwan, 2020 and 2008
(Singapore) Ministry of Manpower Singapore, 2020 (for the data of 2015-19), Wang et al, 2018 (for the data of 2010-15), and author's estimates based on newspaper articles (for the data of 2009 and before)

Liberal Familialism: Contribution of Foreign Domestic Workers

The Hong Kong Research Office of the Legislative Council Secretariat stated in 2017 that FDHs are integral to Hong Kong's community. The 352,000 FDHs represent 9% of the total workforce and work for 11% of local households. Households with children are more likely to employ FDHs, and the proportion tripled from 13% in 1995 to 30% in 2016. Households with children and a working female increased from 23% to 44% during the same period. Strikingly, about two-thirds (67%) of adult members in FDH-employing households did not do any housework in 2013, while 23% of households with members who were disabled or had a chronic disease employed FDHs in 2000. Of married women 25–54 years old with children, if they employed FDHs, 78% of them participated in labour force, whilst if they did not employ FDHs, only 49% of them participated in labour force in 2013 (Research Office, Legislative Council Secretariat, Hong Kong SAR, 2017).

One research in Singapore shows positive effects of hiring FDWs for older people and family caregivers. They report FDWs' support moderated the impairment of physical, memory, and behavioural functions of older people, and sharing the burden of caregiving with FDW could allow family caregivers a more flexible day-to-day schedule although constant caregiving may negatively affect the health and well-being of FDWs (Østbye, et al., 2013).

In Taiwan, the Ministry of Labour surveys employers on the benefits of hiring FDHs. According to the latest survey report, published in 2019, the highest percentage of the respondents (91%) reported that they benefitted from FDHs because FDHs could provide proper care for people who needed it. Other answers were that FDHs could reduce employers' mental stress from caregiving (76%), enable employers to work outside the home (65%), and reduce employers' domestic work (52%) (Ministry of Labor Republic of China, 2019).

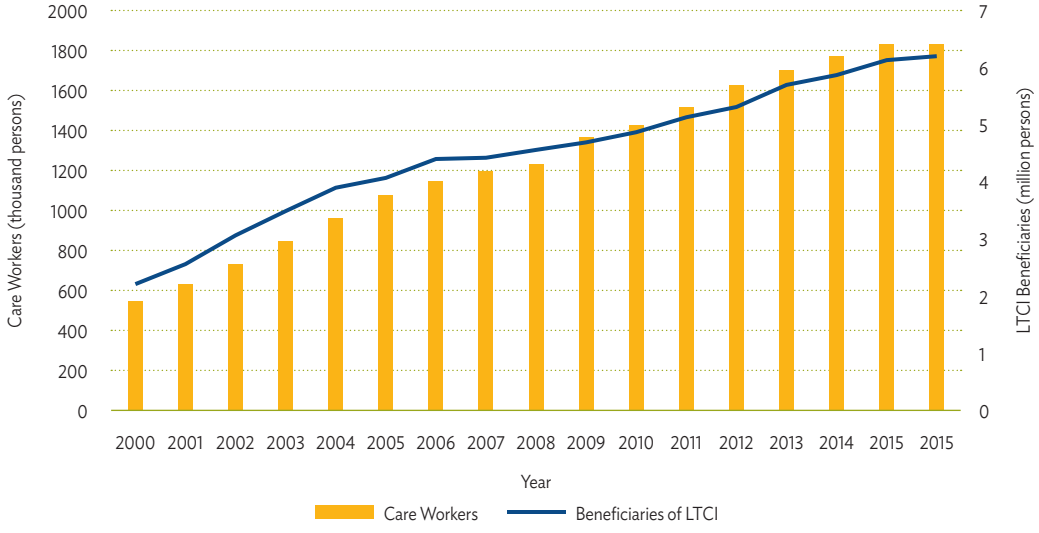
Taiwan is a striking example where hiring FDHs is in principle approved only for households with family members dependent on care. In Singapore, a system of preferential tax treatment is in place for hiring FDHs, which applies to households with members aged 65 or older. The presence of a large number of FDHs supports the continued employment of women outside home whilst securing family care providers.

This liberal familialistic welfare model with migrant workers has the following characteristics: (1) a huge number of migrants are recruited, with more than 900,000 in Hong Kong, Singapore, and Taiwan, almost all women; and (2) women are assumed to have "natural skills" in caring for older people. Therefore, migrants are not required to have specific skills. The model has nothing to do with redistribution. The state's role is not to provide services or cash but to open migration channels and provide employment permits to care-dependent households.

Japanese Long-term Care Insurance and Migration

When long-term care insurance started, Japan had only 549,000 care workers, in the facilities which were accredited by long-term care insurance system, such as long-term care institutions, day service centres, or home-care providers (Figure 1.2). The number more than tripled to 1.83 million in 2016. Long-term care insurance, which aimed to provide the whole country with equally distributed and standardised services, rapidly increased service usage and the number of care workers.

Figure 1.2. Numbers of Long-term Care Insurance (LTCI) Certified Beneficiaries and Care Workers in LTCI-accredited Facilities



Source: Ministry of Health, Labour and Welfare, 2019a.

Care for older people as social rather than individual or family responsibility is supported by a qualification system. One of such qualifications systems is the establishment of the certification system of care workers. Japan's national compulsory long-term care insurance system is designed to provide better payment to the LTCI-accredited facilities which have more certified care workers or *kaigofukushishi* (介護福祉士). Candidates of *kaigofukushishi* have two pathways to be certified: 1) at least 2 years (1,850 hours) of education at accredited care-workers-training school (national examination will be required since 2022), or 2) pass a national examination after at least 3 years of care work experience. Reliable qualification and accreditation of workers and facilities is indispensable to ensure the accountability of the long-term care insurance system, which was established to relieve the burden of family responsibility and to promote the paradigm shift to social responsibility for long-term care. Even though demand for care workers was high, the stringent requirements as well as conservative migrant labour policy of Japan had not allowed recruitment of foreign care workers until 2008, when Indonesian care workers were officially allowed to come into Japan under the Indonesia-Japan Economic Partnership Agreement (EPA). Even though the Japanese government insists the acceptance of foreign

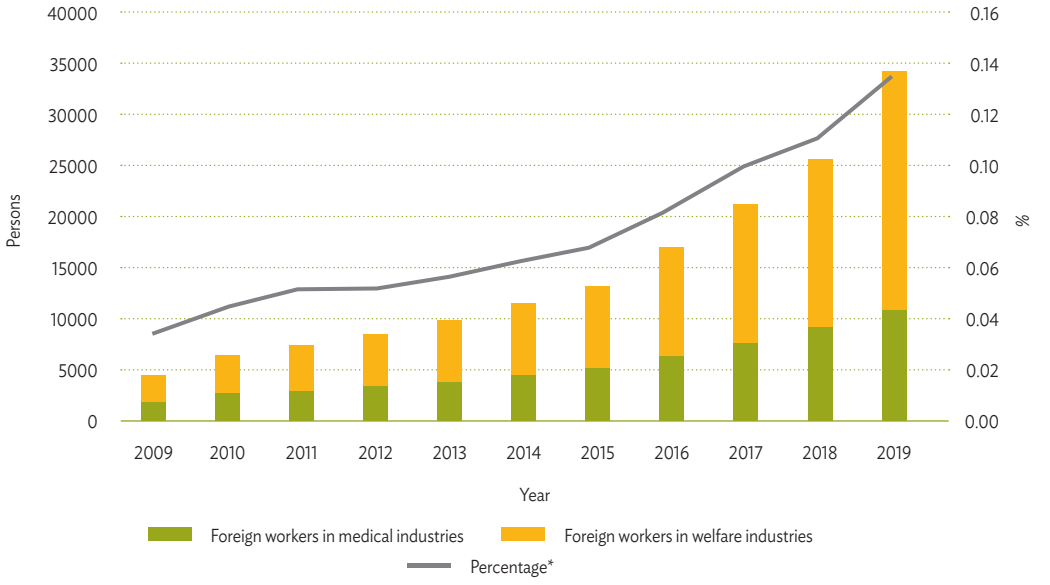
care workers under EPAs is not designed to fill the shortage of domestic care workers, the government decided to expand this program to the nurses and care workers of other countries, i.e. the Philippines in 2009 and Viet Nam in 2014.

The number of migrant care workers in Japan, however, is much lower than in Singapore, Hong Kong or Taiwan. A ministry survey estimated foreign workers at less than 5,000 in 2009, less than 0.04% of the medical and welfare workforce (Figure 1.3). The number of foreign workers in the same sector exceeded 30,000 in 2019 but still only comprised 0.13% of the whole workforce. Until 2017, Japan had had accepted foreign care workers only through EPAs programme. Exact number of active EPA care workers in Japan in certain year is not clear because many of them had already returned to their home countries, but the official data shows the total number of EPA care workers who had started working until 2017 is only about 3,500 (Ministry of Health, Labour and Welfare, 2019b). It can be interpreted that most foreign workers of medical and care industries counted in national survey data were foreign residents who have different status of residence in Japan than that for temporary migrant workers, such as spouses of Japanese nationals, foreign nationals of Japanese descent, etc.

Japanese government expanded the programmes for potential foreign care workers to get work permit of Japan from 2017. In 2017, a new category of status of residence in Japan which is called 'Care Work' came into effect and foreign people who have obtained the Japanese national certification of care work can be granted with this status of residence. Since then, foreign people who intend to get this status of residence have been recruited to training institutions for care work in Japan. Most of such students are engaged in care work as part-time non-certified care workers in long-term care institutions in Japan for 28 hours per week at the maximum. In the same year, Japanese government added a new category of 'Care Work' in Technical Intern Trainee Program (TITP), and the first batch of TITP trainees for care work came to Japan in 2018. The rapid increase of the number of foreign care workers from around 2017 can be caused by such expansions of the programmes for foreign care workers. The number of international students admitted in care worker training institutions increased from 257 in 2016 to 1,142 in 2018 (Carlos, 2020), while the number of TITP trainees for care work was 0 in 2017 but 8,967 in 2020 (Organization for Technical Intern Training, 2020).

In 2019, another new category of status of residence in Japan became effective, which is called 'Specified Skills', and care work is included in the skills specified in this programme. The applicants of this category are required to pass the exams of care skills, and Japanese language proficiency. As a result that the Japanese government has created several new schemes to provide more chances to work in Japan for foreign care workers, it is expected more foreign care workers will be engaged in long-term care practices in Japan. Such trend can be seen in Figure 1.3.

Figure 1.3. Foreign Workers in Medical and Welfare Industries in Japan, 2009–2019



Note : * Percentage = (foreign workers in medical industries + foreign workers in welfare industries) / (total number of employed persons in medical and welfare industries in Japan)

Source : Ministry of Health, Labour and Health, 2020, and Statistics Bureau of Japan, 2019.

Singapore's liberal familialism is very different from Japan's insurance-based socialised welfare regime, so it can be interpreted that the policies to cope with population ageing does not necessarily converge into one common policy. Each country or region might have a more divergent policy, depending on its social, political, or cultural background. Liberal familialism incorporates a huge number of female foreign workers requiring minimal or no skills and knowledge. The relatively low cost of care is paid by family members. The employment tax is a source of revenue, which is the opposite of the welfare state's budget spending.

An insurance-based socialised welfare regime allows recruitment of a small number of qualified migrant workers, usually nurses. In case of Japan, due to the pressure by care industries to lower the qualifications for foreign care workers, several new schemes to accept foreign care workers have been created recently and the policy for the employment of foreign care workers became pretty complicated.

Singapore, Hong Kong, and Taiwan recruit domestic workers from the Philippines, Indonesia, and Viet Nam, all of which have Economic Partnership Agreements with Japan. The recruiting countries have different welfare regimes and require different qualifications, but the countries of origin are the same. Demand for long-term care will increase and the sustainability of care workers will be a significant issue over the next decade.

Outline of Part 2

Part 2 is composed of the chapters discussing Japan as a destination country of foreign care workers, and Indonesia, the Philippines, and Viet Nam as sending countries.

Japan

Japan has set up several new schemes for a limited number of foreign care workers: Economic Partnership Agreements (2008), resident status of 'Care Work' (2017), care work under TITP (2017), and 'Specified Skills' (2019). They are all called 'foreign care workers', but we need to note that each migration channel has different recruiting system and provides different institutional settings which will change diverse experiences to them. Foreign care workers under Economic Partnership Agreements are heavily supported by the government, which shoulders recruitment and training cost, but they must return to their home countries if they eventually fail in Japanese national exam of certified care workers, whilst TITP care workers are responsible for the initial recruitment cost for migrants; in case of the care worker form Viet Nam it is US$800. And foreign care workers who intend to obtain the resident status of 'Care Work' are required to cover the cost for training institution in Japan because this status can be granted to the people who have the qualification of certified care workers, so before applying this resident status, they obtain the resident status of 'student' when they enter care-work training institutions. Foreign students are allowed to work 28 hours per week at the maximum, and they are supposed to shoulder their own living expenses. Various migration channels for foreign care workers confuse potential migrants, and malicious brokers can manipulate applicants.

Foreign care workers are accepted through different channels. In Chapter 3, Tsukada reports the result of a nationwide interview research conducted in 2009–2011 which shows that administrators of long-term care institutions who accepted foreign care workers recruited under EPAs are mostly satisfied with them even though they had concerns about them before they arrived. Tsukada also shows the result of a nationwide mail survey conducted in 2014 which found that most administrators of long-term care institutions or Japanese long-term care workers favoured recruiting foreign care workers if the respondents who answered 'don't know' are excluded. This survey was conducted before the creation of new resident status of 'Care Work' and new TITP category of care work. As a result, no remarkable difference was found amongst their preference in different channels of foreign care workers: EPAs, resident status 'Care Work', and new TITP category. It is notable, however, some respondents had negative impression on TITP because of how it was implemented domestically and internationally. From the perspectives of the countries sending workers to Japan, this complex system for migration channels of care workers should be made simple and transparent, and the Japanese government is highly encouraged to regulate cost mechanisms and collaborate with countries of origin to build a regional framework of certification of care skills and to recruit care workers ethically.

Indonesia

As Susiana shows in Chapter 2, Indonesia started to deploy healthcare workers overseas during the Suharto government (1996) and the migration of Indonesian domestic workers also started in the past decade, who became popular in Hong Kong, Singapore, Taiwan, and some Gulf countries. The Law No. 39 of 2004 was enacted to realise equal rights and opportunities of migrant workers and to obtain decent work and income. The country, however, must deal with poor utilisation of health professionals, regional disparities, ongoing standardisation of nursing, and oversupply and unemployment of nurses. The challenge is how to balance the domestic needs of healthcare workers with big urban–rural disparities and overseas deployment. Can overseas deployment alleviate domestic problems, particularly optimum allocation of healthcare staff? Does sending domestic workers to familialistic welfare regimes – Singapore, Hong Kong, Taiwan, Malaysia, and Brunei – to care for older people help the workers acquire skills whilst being protected? After decades of sending out domestic workers, and as demand for domestic workers increases, the government should reconsider outmigration and human resource development.

The Philippines

As De La Vega mentions in Chapter 4, the Philippines is one of the biggest sources of domestic and care workers and health professionals, including nurses, occupational and physical therapists, and health care workers, for the Middle East, North America, Asia, and Europe. To promote decent work, the government has set up training for caregivers, including childcare, care for older people, and household work, at the vocational level and authorised by the Technical Education and Skills Development Authority. The Economic Partnership Agreement with Japan requires caregivers to be certified. Knowledge and skills to care for people with dementia, however, are not included in the curriculum. Technical cooperation should be standardised, and mutual recognition agreements and the Association of Southeast Asian Nations Qualifications Reference Framework implemented. The Philippines is leading the push for regional qualification as bilateral migration coordination has its limits.

Viet Nam

Khuat discusses the history of migrant Vietnamese workers and migrant care workers from Viet Nam which has been rapidly emerging recently in Chapter 5. Viet Nam, as a country of origin, faces a dilemma between quantity and quality of migration. Viet Nam is new at sending care workers abroad. Caring for older people has never been an established occupation and care workers are poorly regarded, unlike in the Philippines, where caregiving is taken as one of the categories of national qualification. Viet Nam started sending domestic workers to Taiwan and some Gulf countries, but developing professional care workers is a big challenge. The Economic Partnership Agreement with Japan and the Triple Win Program of Germany provided Viet Nam with its first experiences in sending professional care workers abroad, and provided the opportunity to look beyond the conventional image of 'care'. The negative image and low expected wages in Japan, however, discourage workers from going abroad. Unethical brokers charge trainees from Viet Nam extraordinarily high fees, which is the cause of runaways and

crimes and defeats the purpose of overseas deployment – poverty reduction and pursuit of the good life.

Future Direction

The driving force behind temporary migration as the national strategy of overseas deployment remains strong, and sending countries' expectations are enormous: reduce poverty, acquire training and skills, promote decent work, and establish good relations with the countries of destination. Are these expectations met?

Bilateral deployment and recruitment are challenges to regional standardisation and harmonisation. Regional coordination is indispensable to optimise allocation of human resources, to acquire training and skills, and to promote workers' rights. A regional approach would coordinate an increasingly competitive labour market as demand for care increases. More active collaborative studies amongst the experts in the region are highly encouraged to provide the evidence which is required for policymakers to harmonise regional policy on migrant care workers.

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CHAPTER 2

Migration of the Indonesian Care Workforce in Response to the Ageing Population, and Future Challenges

Susiana Nugraha, Tribudi W. Raharjo and Yuko Hirano

Background

International migration occurs in the context of increasing global mobility and growing competition for scarce skills. International labour migration has contributed greatly to the lives of many Indonesian migrant workers, their families, and the economy. More than 9 million Indonesians work abroad, equivalent to nearly 7% of the total labour force. In 2016, migrant workers sent remittances worth more than IDR118 trillion (USD8.9 billion) (World Bank, 2017).

Driven by the growing ageing population, migration of skilled health professionals from developing to developed nations has increased dramatically in recent years and become a preeminent issue in global health. The World Health Organization reported a 60% rise in the number of migrant doctors and nurses working in Organisation for Economic Co-operation and Development countries over the last decade (WHO, 2014). Developed nations have become more reliant on international migrants to fill health workforce positions across the skill spectrum, from home health aides and assistants to nurses, physicians, and medical specialists.

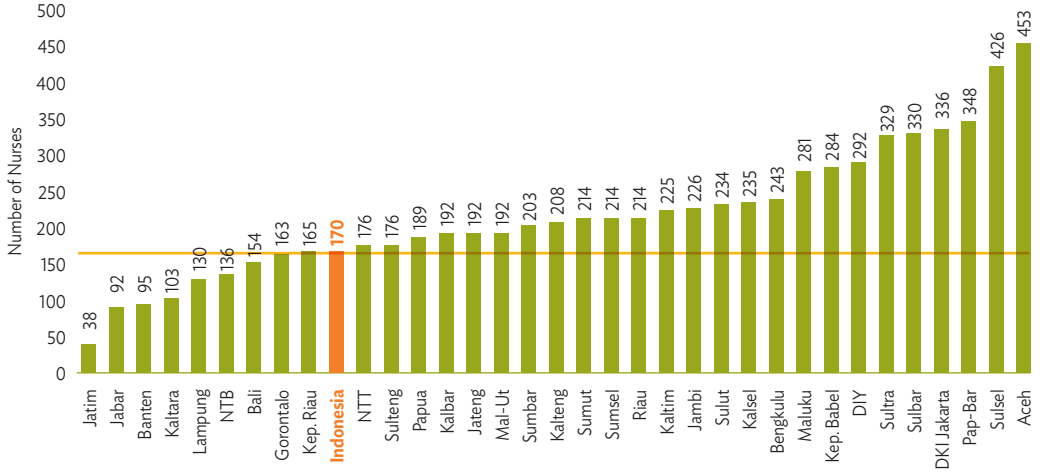
International migration of Indonesian healthcare workers started in 1996, with the United Arab Emirates as the first destination country. This program attempted to address the false 'surplus' problem of nurses in Indonesia (Suwandono et al., 2005). Since then, the Government of Indonesia has made several efforts to promote overseas nurse programs, including improving education, recruitment, and other mechanisms. Various regulations have improved the quality of the care workforce as well as protection for care workforce migrants (Subhan, 2012).

This paper will describe the international migration of the Indonesian care workforce, including caregivers, as a response to the shifting demography of the ageing population. This paper will also provide information on the migration schemes and national policy for placement and protection of the overseas care workforce as well as utilisation of returning migrants.

Situation of the National Care Workforce

Human resource development is a priority of national health development. Indonesia still faces problems related to health personnel – number, type, quality, and distribution.

Figure 2.1. Nurse Distribution per 100,000 of Population by Province



Source : Ministry of Health, Labour and Health, 2017

The national average is 170 nurses per 100,000 thousand residents, or about 1 per 588 people, but the distribution gap between provinces is remain high. Aceh has the most nurses and East Java has the fewest. The ideal ratio is 1 nurse per 855 people (Ministry of Law and Human Rights, 2016). Utilisation of the healthcare workforce remains poor, especially in disadvantaged, remote, border, island, and less-desirable areas (Ministry of Health Republic Indonesia, 2017). As a result, many nurses work in big cities and few go to remote areas. The socio-economic, cultural, and regional government disparities, including geographical conditions between regions, discourage health workers from working in some remote areas in Indonesia.

The number of nursing schools has grown rapidly since government regulations allowed them to do so 10 years ago. Unfortunately, the overall quality of education has gone down. Many nursing schools did not meet national standards, and more nurses are produced than can be absorbed by the domestic labour market. The result is oversupply and unemployment (Efendi et al., 2018).

Working abroad is a solution to such oversupply. Indonesia has been significantly impacted by the free movement of nurses globally, particularly through domestic and international policies that encourage mobility. Some nurses are interested in finding jobs overseas or in other fields such as caregiving, which has simpler qualifications and promises better payment than jobs in the domestic market.

More than 3,000 nurses deployed to developed countries from 2008 to 2012 (BNP2TKI, 2015). International trade agreements and the treatment of health worker migration might further impact the outward flow of nursing professionals. The Indonesia–Japan Economic Partnership Agreement (IJEPA), for example, facilitates a pathway for Indonesian nurses to immigrate to Japan.

Many studies approach the IJEPA from the perspective of Japanese researchers and policymakers, but little has been written from the viewpoint of Indonesia. We aim to fill this gap in the literature by discussing the current Indonesian nurse human resource environment, describing the factors influencing the country's shortage of nursing professionals, and assessing how Indonesia's participation in international and regional agreements impacts health worker migration and recruitment.

Care Workforce Migration

The migration of caregivers for the elderly started in the past decade. Hong Kong, Taiwan, Singapore, and Saudi Arabia are recruiting the most caregivers from Indonesia. Migration is mainly through private companies that send workers abroad.

Generally, caregivers are in the domestic household sector and need to fulfil only administrative and language requirements. Candidates are trained by the sending company and take a competency test at the end of training. Those who pass are dispatched to the destination country.

Caregivers abroad perform two kinds of work:

- care for the elderly at institutions for neglected elderly people; and
- care for households, of which the family which is the smallest unit, consisting of husband and wife, or husband and wife and their children, or father and child, or mother and child.

Taiwan, Hong Kong, Singapore, and countries in the Middle East need caregivers to manage the environment of the elderly, groom and feed them, help them move, prevent accidents, respond to emergencies, report on the care given, and communicate in the language of the placement country. Overseas requests for Indonesian care workers continuously increased in 2010–2020.

Table 2.1. Migrant Distribution by Occupation

No	Occupation	2014	2015	2016	2017	2018
1	Domestic Worker	136,120	61,023	46,402	96,041	93,124
2	Caregiver	49,521	51,772	54,160	44,033	51,386
3	Operator	48,119	35,187	32,411	31,367	36,005
4	Plantation Worker	47,790	38,526	30,834	26,470	25,108
5	Worker	24,069	20,311	27,917	23,900	26,668
6	Construction Worker	10,761	4,928	2,853	1,831	2,038
7	Housekeeper	7,773	6,839	3,757	1,616	1,471
8	Cleaning Service	5,093	2,773	2,416	1,817	1,440
9	Fisherman	4,852	1,866	692	2,819	2,620
10	Waiter	3,245	2,310	1,426	1,670	1,215
11	Driver	7,467	1,278	388	242	345
12	Cleaners	2,379	4,521	1,803	381	277

No	Occupation	2014	2015	2016	2017	2018
13	Gardener	3,214	2,245	1,211	1,386	843
14	Sanitation Officer	981	1,594	1,090	376	365
15	Farmer	890	776	977	1,147	532
16	Agricultural Labour	1,302	699	301	475	542
17	Cooks	1,267	634	323	387	259
18	Nurse	930	466	178	240	227
19	Steward	1,380	235	11	96	65
20	Cook	655	144	10	2	7
21	Other	72,066	37,610	25,291	26,603	39,103
	TOTAL	**429,874**	**275,737**	**234,451**	**262,899**	**283,640**

Source : National Body for Placement and Protection of Overseas Workers

Table 2.1 shows that caregiving is the second most common job performed by Indonesian overseas workers, totalling 51,386. Domestic workers make up the largest group of Indonesian migrants, with many caring for the elderly at home.

Care Workforce Migration under the Japan–Indonesia Economic Partnership Agreement

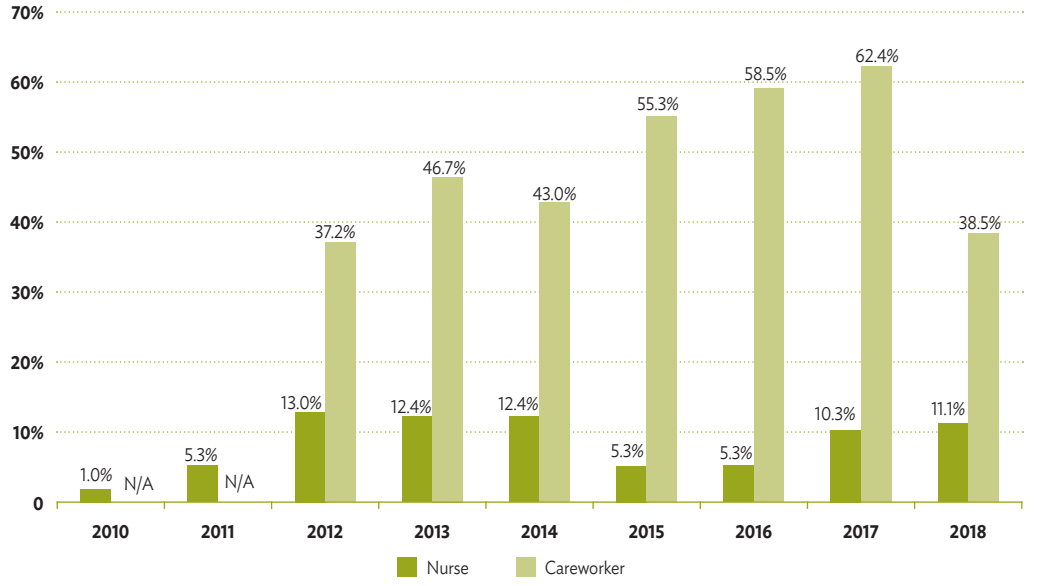
Starting in 2008, Japan opened its labour market to the foreign care workforce, especially nurses and certified care workers. The agreement's chapter on movement of natural persons encourages Indonesian healthcare professionals to work in Japan under prescribed conditions (Ministry of Trade Republic Indonesia, 2007). Healthcare migration is the first system to involve a government -to -government cooperative program underpinned by the intention to promote free trade (Hirano et al., 2012).

The program allows Indonesian care workers into Japan provided nurse candidates are certified nurses in Indonesia with more than 2 years of experience, and caregiver candidates (1) have a bachelor or associate degree (D3) and a caregiver license issued by the Indonesian government or (2) are certified nurses in Indonesia (Ministry of Health Labour and Welfare Japan, 2014). Most recruitment and coordination procedures are conducted by the National Board and the Japan International Cooperation of Welfare Service. These agencies hold a competitive selection to choose candidates and coordinate with Japanese hospitals or care institutions where candidates will work. Selected candidates learn Japanese language in Indonesia for 6 months and in Japan for another 6 months. After language training, candidates are dispatched to host hospitals or care facilities.

Indonesian nurses who migrate to Japan are designated as 'candidates' until they pass Japan's national board examination, conducted in the Japanese language, for registered nurses and certified care workers (Ministry of Health Labour and Welfare of Japan, 2014). Whilst preparing for the national board examination, the candidates may work as trainees at medical institutions and/or long-term care facilities in Japan. The contract allows for a maximum stay of 3 years for nurses and 4 years for certified caregivers to work as candidates. If they pass the national board examination within these durations, they are licenced as registered nurses or certified care

workers. They may stay and work in Japan for 3 years until visa renewal, which can be done in perpetuity as long as they work as a nurse or certified care worker. If they fail the national board examination, they must return to Indonesia (Ministry of Health, Labour, and Welfare of Japan, 2014).

Figure 2.2. Passing Rate of Indonesian Nurse and Certified Caregiver under Japan–Indonesia Economic Partnership Agreement



Source : Ministry of Health, Labor, and Welfare Japan (2018).

Figure 2.2 shows that the passing rate amongst Indonesia nurses is low, which is due to socio-cultural issues and different nursing systems in the two countries (Nugraha and Ohara-Hirano, 2014; Setyowati et al., 2010), whilst that for caregivers is better, since they have a nursing education background.

National Regulations on International Labour Migration

Law No. 39 of 2004 concerning in the placement and protection of Indonesian migrant workers is part of an effort to realise equal rights and opportunities for workers to obtain decent work and income. Article 1, number 3 states that the government is in charge of supervising the entire process of recruitment, document processing, education and training, housing, preparation for departure, protection of workers in the destination country, and the return of workers to Indonesia. The government has improved the quality and capacity of Indonesian migrant workers by doing the following:

- Implement Presidential Instruction Number 06 of 2006 concerning Reform of Policy for Placement and Protection of Indonesian Migrant Workers Abroad, by simplifying the bureaucracy of migrant worker placement services, including the placement procedure.

- Ease the burden borne by overseas worker candidates by eliminating fiscal fees, the cost of arranging the foreign worker card (kartu tenaga kerja luar negeri [KTKLN]), and the cost of pre-departure orientation.

- Improve the quality of overseas worker candidates through training in skills, abilities, and language, and mental preparation. The government will place only Indonesian migrant workers (tenaga kerja Indonesia [TKI]) considered to have fulfilled competency requirements as evidenced by a certificate from the professional certification institution (lembaga sertifikasi profesi) appointed by the Ministry of Manpower and Transmigration.

- Protect the rights and property of Indonesian migrant workers through TKI insurance programs implemented by five insurance consortia, which must cooperate with legal aid agencies and/or lawyers in migrant workers' countries.

Migration of the Indonesian workforce is in accordance with the following International Labour Organization conventions:

1. Convention No. 87/1948 concerning Freedom of Association and Protection of the Right to Organize and Collective Bargaining (Freedom of Association and Protection of Right to Organize)

2. Convention No. 98/1949 concerning the Application of the Principles of Right to Organize and Collective Bargaining (Application of the Principles of Right to Organize and to Bargain Collectively)

3. Convention No. 29/1930 concerning Forced or Compulsory Labour

4. Convention No. 105/1957 concerning the Elimination of Forced Labour (Abolition of Forced Labour)

5. Convention No. 138/1973 regarding the Minimum Age Limit to be Allowed to Work (Minimum Age for Admission to Employment)

6. Convention No. 182/1999 concerning Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour

7. Convention No. 100/1951 about the same wages for the same work

8. Convention No. 111/1958 concerning Discrimination in Work and Position

Refer to Act No. 39/2004 has five placement schemes for TKI, as follow:

1. Private-to-private (P-to-P) placement is facilitated by a private company in Indonesia (through the Indonesian Recruitment, Employment and Manpower Agency [Pelaksana Penempatan Tenaga Kerja Indonesia Swasta (PPTKIS)]) and destination countries. Agents of private recruitment agencies from Indonesia engage with private employment agencies in the destination country. End users may be legal entities such as nursing homes and individuals. Placement to Malaysia, Singapore, Taiwan, the Middle East, New Zealand, and several countries in Europe is still fully carried out this way. The Indonesian Labour Providers Organization (Perusahaan Jasa Tenaga Kerja Indonesia) is responsible for the scheme. The entire process is supervised by the government through the National Body for Placement and Protection of Overseas Workers (Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia [BNP2TKI]). The economy with the biggest P-to-P scheme for caregiver placement is Taiwan, which has fewer pre-employment requirements than Japan. This is partly because Taiwan has only two types of payroll systems: formal (TWD20,080) and informal (TWD17,500). A caregiver may graduate from high school or even junior high school by first training at a technical and vocational education and training centre (Balai Latihan Kerja [BLK]) for 600 hours (depending on the country of placement).

2. Placement of Indonesian individuals does not involve recruitment agencies or government and is usually for professional workers with certain educational backgrounds and special skills, who can migrate independently. The process is carried out between the employer and the prospective worker. Many nurses, doctors, and engineers are recruited this way.

3. Government-to-government (G-to-G) placement is facilitated under a memorandum of agreement between the governments of Indonesia and destination countries, i.e. the Republic of Korea and Japan. Overseas placement is facilitated, carried out, and supervised directly by Indonesia's BNP2TKI, with users or end users in the country of placement, which are government agencies or private companies. For example, Indonesian migrant workers may go to the Republic of Korea as a result of BNP2TKI working with the Human Resources Development Services of Korea, appointed by the Ministry of Labour of Korea, or with Japan International Corporation of Welfare Services, established by the Ministry of Labour of Japan.

4. Government-to-private (G-to-P) placement is facilitated by the Indonesian government with private companies in destination countries, e.g. companies in Penang, Malaysia.

5. Private foreign companies may hire experts or professionals in Indonesia to work for them abroad.

1. Basic requirement for overseas placement

Job seekers referred to above must meet the following requirements:

a. At least 18 years of age. Exception: Workers to be employed by individuals must be at least 21, proven by a resident identity card (kartu tanda penduduk [KTP]) or electronic resident

identity card (e-KTP) and birth certificate or similar proof from an authorised agency.

b. Certificate of health and evidence from a doctor stating that female participants are not pregnant.

c. Permit from husband, wife, parent, or guardian who is known to the village leader.

d. Card from the district or city office showing the worker is registered as a job seeker.

e. Educational qualifications and requirements required by the employer.

2. The new track for care workforce migration to Japan

Aside from the Japan–Indonesia Economic Partnership Agreement, the Technical Intern Training Program (TITP) and international student visa program, which allows foreign caregivers for the elderly to enter Japan, was launched on 1 November 2017.[1]

a. Technical Intern Training Program (TITP)

In conjunction with enforcement of the new Technical Intern Training Act, 'care worker' was added to occupations subject to the TITP. The technical intern trainee candidates must have at least a certain level of Japanese language ability to ensure that they can communicate with technical intern training instructors, who give guidance on skill acquisition, users of care worker facilities, and others. Accordingly, technical intern trainees must satisfy the following Japanese language requirements (Japan International Training Cooperation Organization, 2019):

1) Technical intern trainees (first year). Pass at least the N4 Japanese Language Proficiency Test.

2) Technical intern trainees (second year). Pass the N3 Japanese Language Proficiency Test.

Before leaving for Japan, candidates will have 6 months of training in basic Japanese language in Indonesia until they pass level N4. After being assigned a place of work in Japan, participants will attend 2-month pre-departure training in Indonesia. In Japan, they will train for 1 month before being dispatched to the care facilities. After working in Japan for a year, participants must take an N3-level Japanese language proficiency exam. If they do not pass, they will be sent back to Indonesia; if they graduate, they will continue to work for 2 years, for a total of 3 years. According to the announcement by the dispatch agency (Bahana Inspirasi Muda, 2018), the cost for the TITP program is JPY350,000, shouldered by the applicants. Costs include: training materials (handouts, audio, videos); dormitory residences; and facilities during training (bedding, cookware, internet, water, and electricity); uniforms; and slippers.

[1] At the time of writing, no other programmes exist, but as of February 2021, another pathway for foreign care workers in Japan is effective: a new residence status of 'Specified Skilled Workers'. The details can be found on the following website: https://www.ssw.go.jp/en/ or https://www.jitco.or.jp/en/skill/ (accessed 8 February 2021).

b. International student visa program

Applicants who meet the administrative requirements and pass the Japanese language proficiency examination may enter Japan on a student visa. After arriving, they attend Japanese language lessons in the morning for 1.5–2 years. In the evenings, they work as interns in nursing homes for 28 hours per week at most. After graduating from Japanese-language school, students immediately take *kaigo* education for 2 years. Students continue their internship in nursing homes. If they complete their education, they receive an official certificate stating that they are now *kaigofukushi-shi* (care worker) who meet Japan's standards. Graduates officially become permanent workers forever. The 2-year program cost of JPY1,300,000 is shouldered by the applicants (PT MINORI, n.d.; PT.OS Selnajaya, n.d.).

Some institutions support students with scholarships, charging only JPY450,000 for the first year's tuition and housing (PT JIAEC, 2018) (PT JIAEC; PT MINORI, no date; PT. OS Selnajaya).

Table 2.2. Caregiver Migration Scheme, Stipulated by the Government of Japan

	Economic Partnership Agreement	Technical Intern Training Program	International Student Visa
Migration scheme	**Government to government**	**Private to private**	**Private to private**
Who may apply	Graduate of 4-year course or of nursing school or 3 years diploma of nursing	Anyone over 18 years old, minimum High School Graduate	High school graduate
Required Japan language proficiency	Not applicable in the meantime N4 level (requirement)	N4 or N3	N2
Training opportunities	Caregiving training, national exams, Japan International Corporation of Welfare Services	Private organisations	Part-time job, on-the-job training
Benefits of working in the long-term care industry	Wages and employment, experience in a new working atmosphere	Wage and employment	Wage and employment
Cost of long-term care industry	Salary and recruitment fees (including training fee, airfare, allowance, amongst others)	Salaries paid to management group	No need to shouldered any payment, part time work salary
Risk of long-term care industry	Qualifications not established	Inadequate communication, accident, disappearance	Inadequate communication, accident
Cost to foreign workers	Almost none	Pre-departure training cost, airfare, dormitory	Airfare, pre-departure selection cost, tuition for Japanese language school, and agency cost
Risk for foreign workers	Fail national exam	Debt cannot be recovered. Cannot change employer in case problems arise.	Unable to recover the debt, difficulties in finding an employer, which may cause visa permit problem
Cost shouldered by applicant	JPY13,000 for preliminary selection	JPY350,000 for training fee, airfare, etc.	JPY450,000 for tuition fee and living cost for first year

Conclusions

The migration of care workers for the elderly is a necessity in the era of population ageing. By 2030, 70% of Indonesia's population is projected to be of working age, presenting an

opportunity and a challenge. The main benefit of migration is prosperity at home, but it hinges on creating enough jobs for the 2 million or so workers who enter the labour market each year. Comprehensive assistance, protection, and supervision are needed to maintain their capacity and quality. Migration is a way of transferring knowledge as Indonesia will see its own population age.

All stakeholders should utilise caregiver personnel in an integrated manner so that they will improve and be competitive in domestic and foreign markets. Mobilizing migrant workers to meet the care needs of an increasing elderly population is a challenge for provider countries such as Indonesia. The government should pass regulations to open formal education for care workers to meet demand in foreign and domestic markets.

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CHAPTER 3

A New Era for Policies for Care Workers in Japan: Current Status and Future Directions*

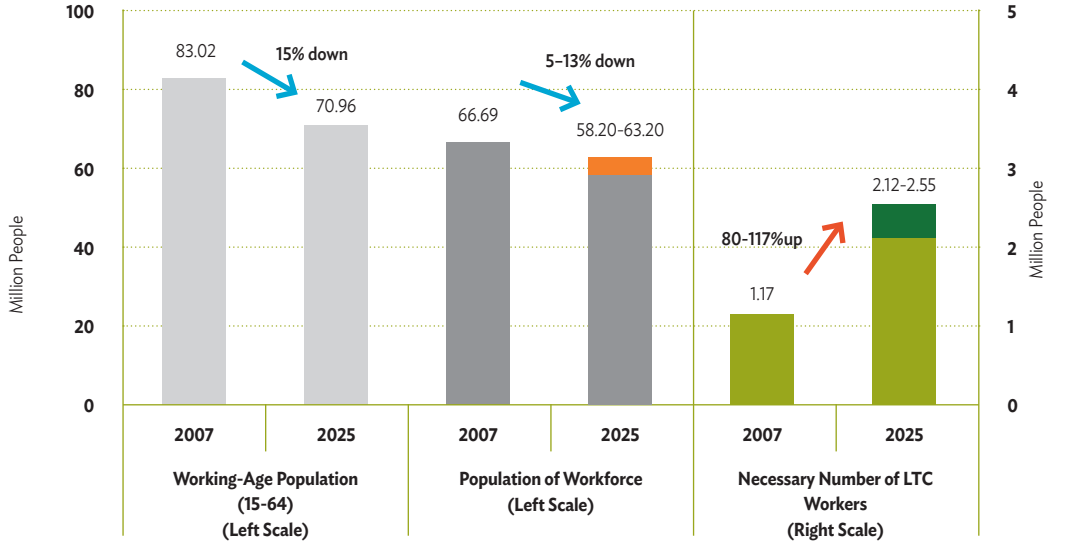
Noriko Tsukada

This paper briefly introduces the status of the care workforce in Japan, then reports on new policies on foreign care workers. It presents outcomes from nationwide interview research in 2009—2011 and a mail survey in 2014.* Finally, it discusses future directions for care workers.

Status of Care Workers in Japan

With its continuously declining fertility rate, which was 1.36 in 2019 and far below the population replacement level of 2.1, Japan is quickly becoming the world's fastest and oldest ageing society. The proportion of older adults amongst the total population was 28.7% on September 2020. Long-term care (LTC) services are required to help older citizens.

Figure 3.1. Working Age Population (15–64), Workforce, and Number of Care Workers Needed, 2007 and 2025



LTC= long-term care.

Source: Ministry of Health, Labour and Welfare (2010)

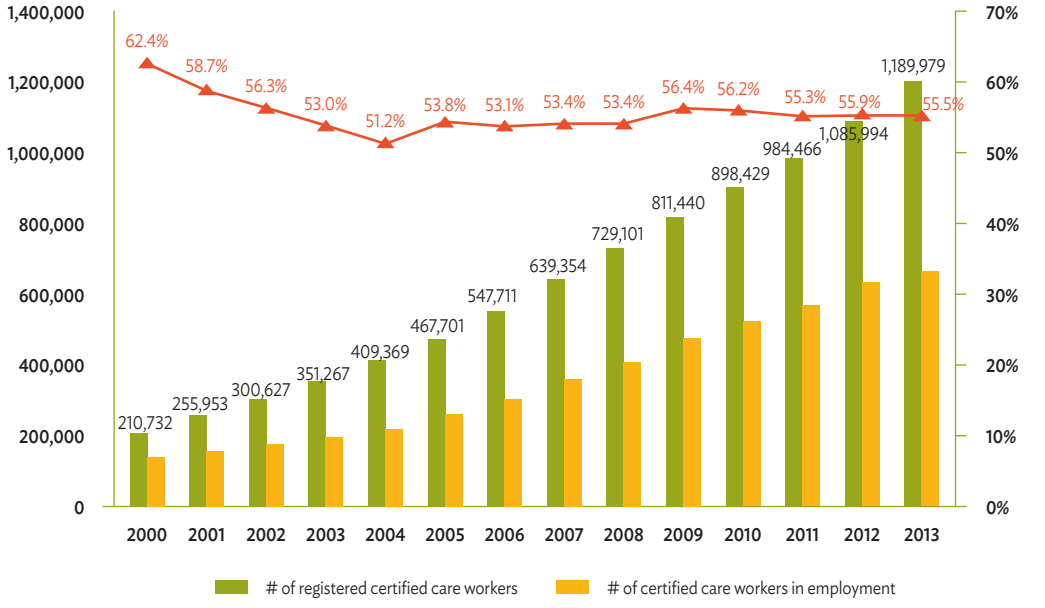
* The research was supported by JSPS KAKENHI Grant Numbers 21530609 and 26380653.

Japan launched a public LTC insurance program in 2000. Not surprisingly, the number of persons certified as requiring and using LTC services under the program has been steadily increasing since then, which means that Japan needs more care workers.

Figure 3.1 shows that the working-age population and workforce are projected to decrease while the number of care workers needed is projected to increase. Yet, the number of training schools for care workers in Japan has been decreasing and so has the number of admission slots for students. There were more than 450 training schools in 2005 but only 378 in 2013. Not only has the number of admission slots in training schools decreased but only 70% are filled, suggesting that younger people able and willing to care for frail and dependent older adults have been decreasing, worsening already existing workforce shortages.

Figure 3.2 shows trends in numbers of registered certified care workers (*kaigo-fukushi-shi*) and proportions of certified care workers who are working as care workers. Figure 3.2 shows that only about 56% of certified care workers are working as care workers. Why might this be?

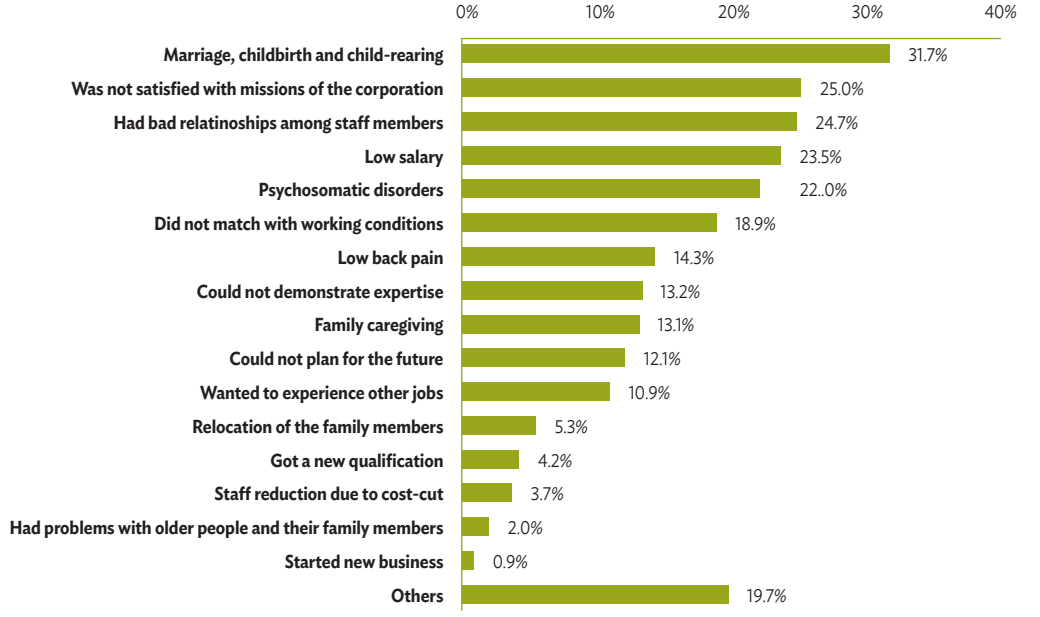
Figure 3.2. Registered Certified Care Workers (*Kaigo-Fukushi-Shi*) and Certified Care Workers Working as Care Workers



Source: Ministry of Health, Labour and Welfare (2015), p.5.

Figure 3.3 presents many reasons why certified care workers quit their care worker jobs. The most cited one was 'marriage, childbirth, and child-rearing (31.7%),' followed by 'not satisfied with missions of the corporation (25%),' 'bad relationship among staff members (24.7%),' and 'low salary (23.5%).' After a family role change, the top three reasons were management issues, all of which can be solved to improve working conditions and encourage continued employment.

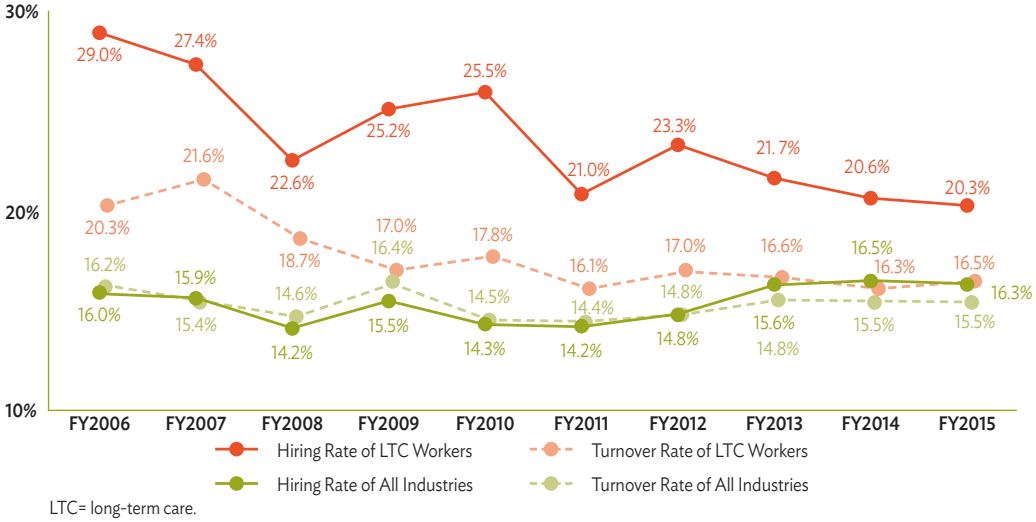
Figure 3.3. Reasons Why Certified Care Workers Quit Previous Care Worker Jobs



Source: Ministry of Health, Labour and Welfare (2015), p.20.

Figure 3.4 shows that hiring and turnover rates for care workers are higher than for all industries although the gap between them has been decreasing. As of fiscal year 2015, the turnover rate for care workers (16.5%) was close to that for all industries (15.5%). In 2015, the Ministry of Health, Labour and Welfare estimated the gap between care worker supply and demand at 0.37 million by 2025.

Figure 3.4. Hiring and Turnover Rates for Care Workers and Workers in All Industries



LTC= long-term care.

Source: Medical, LTC and Welfare Policy Research Forum (2017), p.6.

New Policies on Foreign Care Workers

The government of Japan adopted four drastic policy options on foreign care workers to increase the supply of care workers overall. The first involved recruiting certified care worker candidates based on the Economic Partnership Agreement (EPA) with Indonesia in 2008, followed by the Philippines (2009), and Viet Nam (2014). The EPA aims to strengthen economic relationships, not to cope with shortages of care workers. The Ministry of Health, Labour and Welfare (2016a) reported that 2,106 EPA-certified care worker candidates had entered Japan under a status of residence, *tokutei katsudou* (designated activities), since 2008 as of 1 January 2016. Who are they? They are well educated. Indonesian care workers, for example, graduates of higher education institutions (3 years) AND certified as nursing care workers by the Government of Indonesia, or graduates of nursing schools (3 years) or of university nursing schools. After 3 years of working in Japan, they can take the national qualification examination to become a certified care worker. The government ensures that they earn as much as Japanese care workers with the same qualifications.

The second option was the creation of a new status of residence-*kaigo* (nursing care) enacted in September 2017, which now allows foreigners to work as LTC workers if they meet Japan's standards for care workers. The government also added a category of *kaigo* (nursing care) to an already existing status of residence, *ginou-jissyu* (technical intern training) program, which encompassed 77 job categories when the policy was enacted in November 2017. It allows foreigners with Japanese language proficiency test (JLPT) level 4 to work in Japan for up to 5 years and to learn Japanese LTC skills for the purpose of technology transfer. If they pass a national qualification exam for care workers, they can stay and work as care workers under a status of residence, *kaigo* (nursing care), mentioned above.

Some issues have remained unsolved in the *ginou-jissyu* (technical intern training) program. The biggest one includes 'an assurance of fundamental human rights of foreign trainees'(e.g., protection against exploitation or confiscation of passports). The program should be continuously and rigorously monitored. Another concern is whether JLPT level 4 is high enough for care workers.

The fourth option was enforced on 1 April 2019. The government amended the immigration law on 8 December 2018 and created a new status of residence, *tokutei ginou ichi gou* (specified skilled worker (i)). This policy aims to increase the workforce in 14 areas such as construction, fishery, food service, building cleaning, accommodation industry, aviation industry, agriculture, *kaigo* (nursing care), amongst others, where workforce shortages are serious. Foreign LTC workers under *tokutei ginou ichi gou* (specified skilled worker (i)) are allowed to start working as care workers if they meet certain criteria for specific LTC skills and language proficiency (JLPT level 4) and to stay for up to 5 years. As of 2018, up to 60,000 foreign LTC workers were planned to be accepted over the next 5 years (Ministry of Health, Labour and Welfare, 2018).

Outcome of Nationwide Interview Research of 2009–2011 and Mail Survey of 2014

1) Nationwide Interview Research of 2009—2011

The study aimed to find out how administrators of LTC institutions for older adults that accepted EPA certified care worker candidates viewed their experience and to determine what problems they encountered. Although eight major questions were asked, responses to the second question, 'Did you see or feel the following four types of concerns about the EPA certified care worker candidates who are deployed in your institution?' are introduced here (Tsukada, 2014, 2017).

Four concerns were whether the candidate (i) could write case records and work records in Japanese, (ii) could communicate with their colleagues efficiently or leave and receive instructions about case work, (iii) could communicate efficiently with nursing care clients in Japanese, and (iv) would encounter prejudice from clients.

The typical response for each concern is shown below:

(i) 'After 1 year, they still find it difficult to write nursing care records by themselves, and we therefore have them read (instead of asking them to write) the records.'

(ii) 'In the beginning, they were "hesitant to communicate" or "did not know what to say." But they improved gradually and after 6 months or so, they got to a point where they "were able to manage simple communication," and "were able to understand what was said, somehow," by Japanese personnel speaking slowly and using easier words.'

(iii) 'Many residents have dementia-related problems. But candidates have a good reputation here because they tend to speak clearly and slowly by using polite and easy words. It is true that their "gentleness" can be understood by people who are around them.'

(iv) 'No problems.' 'These EPA certified care worker candidates from overseas were well-liked, encouraged, and given many compliments about their work by the facility residents they had served.'

Of course, some institutions had difficulties dealing with EPA certified care worker candidates such those who (i) would not study the Japanese language seriously, saying 'I am not smart, so I cannot understand Japanese. Will you let me work instead?' (ii) asked for longer vacation periods to go home; (iii) asked for higher salary and bonuses; and (iv) sent lots of money to their home countries, leaving them with little to live on in Japan.

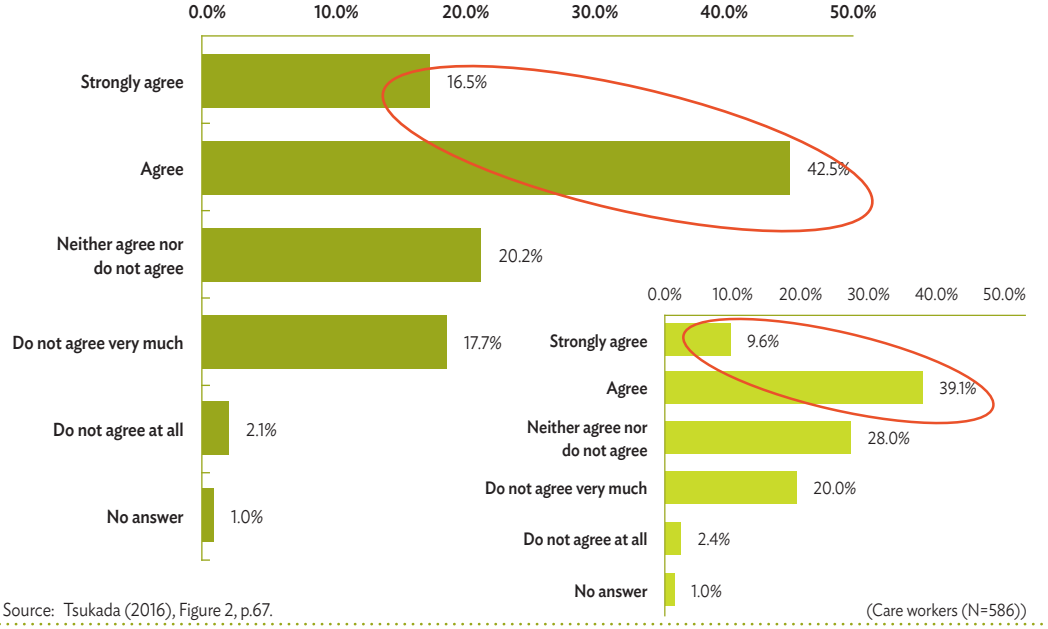
Administrators had many concerns before the arrival of EPA certified care worker candidates, but most were groundless or were exaggerated. Administrators came to feel there was a lot to learn from EPA certified care worker candidates such as smiling, sincerity towards nursing care clients, fundamentals of social welfare, humour, and gentleness. Administrators liked to help them study for the national certification exam. It is safe to say that the vast majority of candidates were performing very well.

2) Nationwide Mail Survey of 2014

The purpose of the mail survey was to explore LTC institution administrators' views on foreign care worker policy options, including recruiting EPA candidates, creating a new status of residence, *kaigo* (nursing care), and adding a new *kaigo* (nursing care) category to *ginou-jissyu* (technical intern training) program. A stratified random sampling was employed. Structured questionnaires were sent to randomly selected 3,932 LTC institutions for older adults from September to October 2014. Response rates were 18.4% for administrators (N=722) and 14.9% for care workers (N=586).

Figure 3.5 shows administrators' views on accepting foreign care workers. The care workers' response to the same question is in the lower right corner. About 60% of administrators agreed 'this would be a good idea.' The proportion of the response to the same question was lower for care workers (about 49%), showing they were a little more reluctant than administrators to work with foreign care workers.

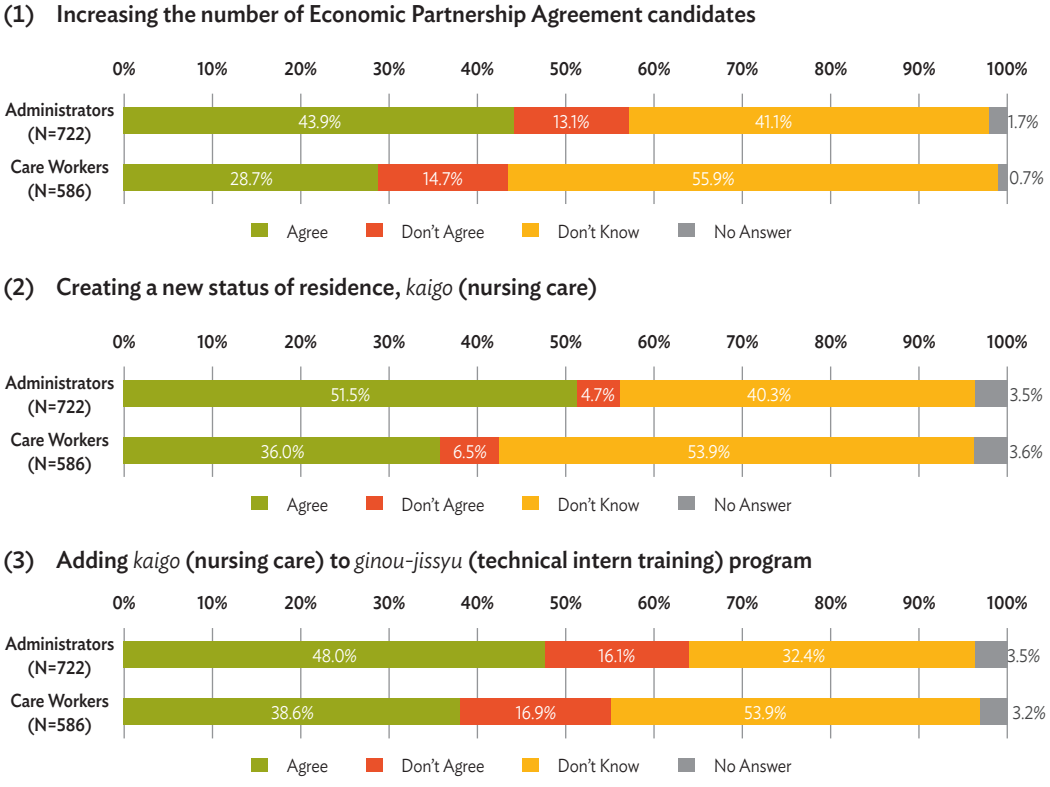
Figure 3.5. Administrators' Views on Accepting Foreign Care Workers (N=722)



Source: Tsukada (2016), Figure 2, p.67.

Figure 3.6 shows views on three foreign care worker policy options. Administrators indicated they were in the greatest agreement about 'creating a new status of residence, *kaigo* (51.5%),' followed by 'adding *kaigo* area to *ginou-jissyu* (48%),' and 'increasing the number of EPA candidates (43.9%).' Amongst care workers, only 36%, 38.6%, and 28.7% agreed.

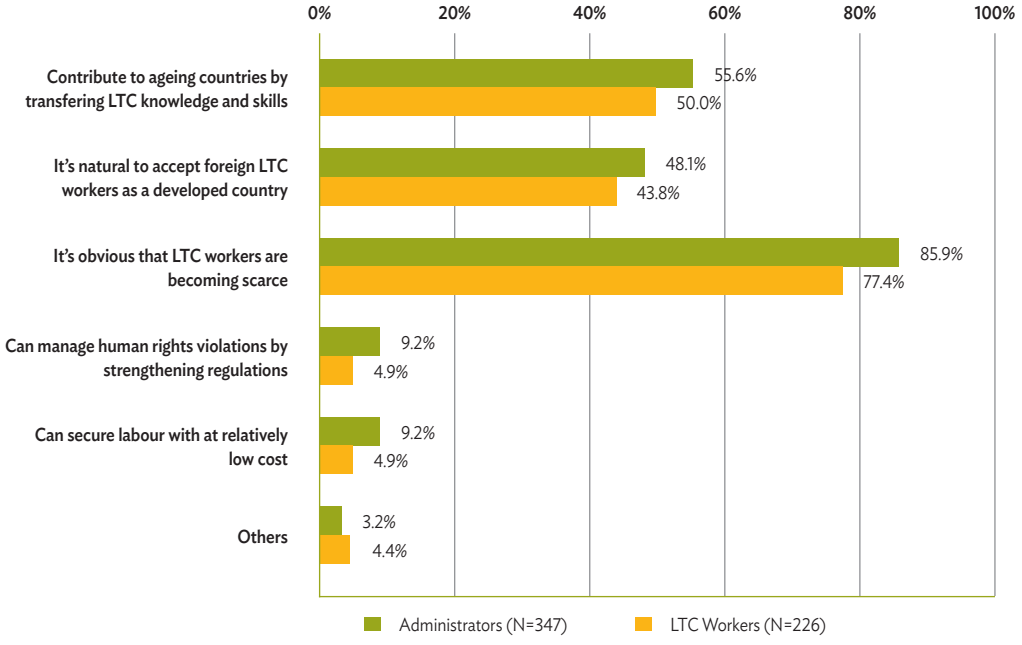
Figure 3.6. Results for Views on 3 Policy Options



Source: Tsukada (2016), Figures 3–5, p.70.

Figure 3.7 shows why respondents agreed with the third policy option. Figure 3.7 shows that the most cited reason amongst administrators was 'It's obvious that LTC workers are becoming scarce (85.9%),' followed by 'Contribute to ageing countries by transferring LTC knowledge and skills (55.6%),' and 'It's natural to accept foreign LTC workers as a developed country (48.1%).' Care workers' answers were similar to administrators'.

Figure 3.7. Reasons Why Respondents Agreed with 'adding *kaigo* to *ginou-jissyu* program'



Source: Tsukada (2015), Figure 4, p.79.

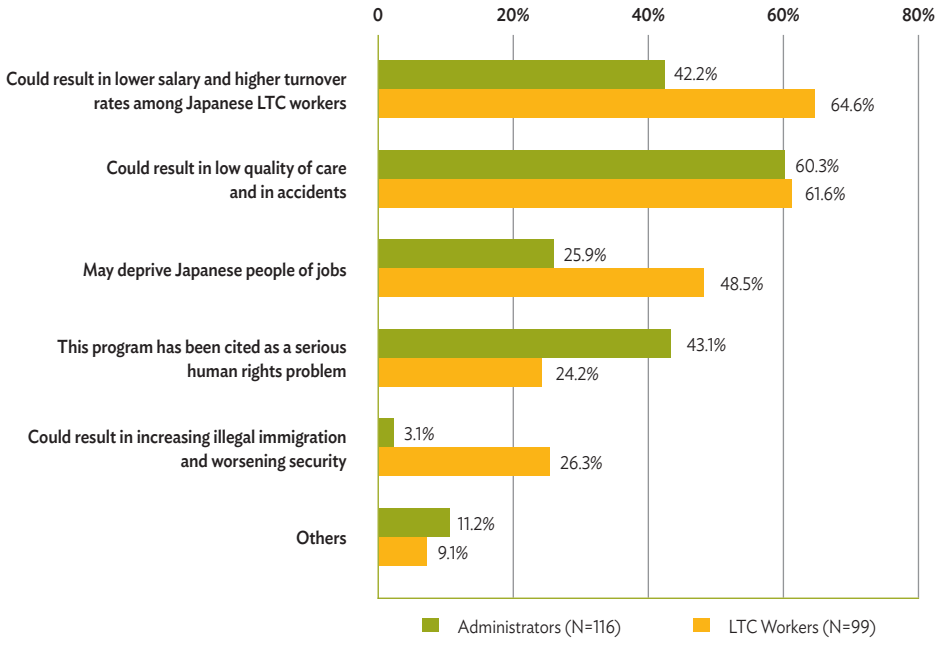
Figure 3.8 shows why respondents did not agree with the third policy option, 'adding *kaigo* to *ginou-jissyu* program.' The most cited reason amongst administrators was 'It could result in low quality of care and in accidents (60.3%),' followed by 'This program has been cited as a serious human rights problem (43.1%),' 'It could result in lower salary and higher turnover rates amongst Japanese LTC workers (42.2%).'

However, care workers did not agree with the third policy option for different reasons. The most cited reasons was 'It could result in lower salary and higher turnover rates among Japanese LTC workers (64.6%),' followed by 'It could result in low quality of care and in accident (61.6%)' and 'May deprive Japanese people of jobs (48.5%)' and 'Could result in increasing illegal immigration and worsening security (26.3%).' Thus, care workers showed higher response rates than administrators, likely reflecting their feeling of insecurity.

(3) Future Directions

The Government of Japan has just started implementing new policies on accepting foreign care workers, hoping to increase the number of care workers. In 2016, however, foreigners made up only 1.9% of Japan's total population and foreign workers made up only 1.6% of the total working population (JILPT, 2018). It is safe to say that the Japanese population is not accustomed to working with foreign workers.

Figure 3.8. Reasons Why Respondents Did not Agree with 'adding *kaigo* to *ginou- jissyu* program'



Source: Tsukada (2015), Figure 4, p.79.

Japan is facing a substantial care workforce shortage. Options to solve this problem include increasing the number of EPA certified care worker candidates; attracting more older adults, women, and young people into the profession, including NEET (those not in education, employment or training) (about 0.26 million in 2015); calling inactive certified care workers (0.51 million) and home helpers back to the LTC field; and loosening status of residence requirements to accept foreign LTC workers.

The government set three goals: (i) call back displaced care workers; (ii) increase new entrants, including students and middle-aged and older Japanese citizens; and (iii) increase retention rates of care workers (Ministry of Health, Labour and Welfare, 2016b). To achieve these goals, however, working conditions should be improved, otherwise even foreign care workers will leave jobs that Japanese people do not want. Why? We are, after all, the same people.

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CHAPTER 4

The Philippine Health and Care Workforce in an Ageing World

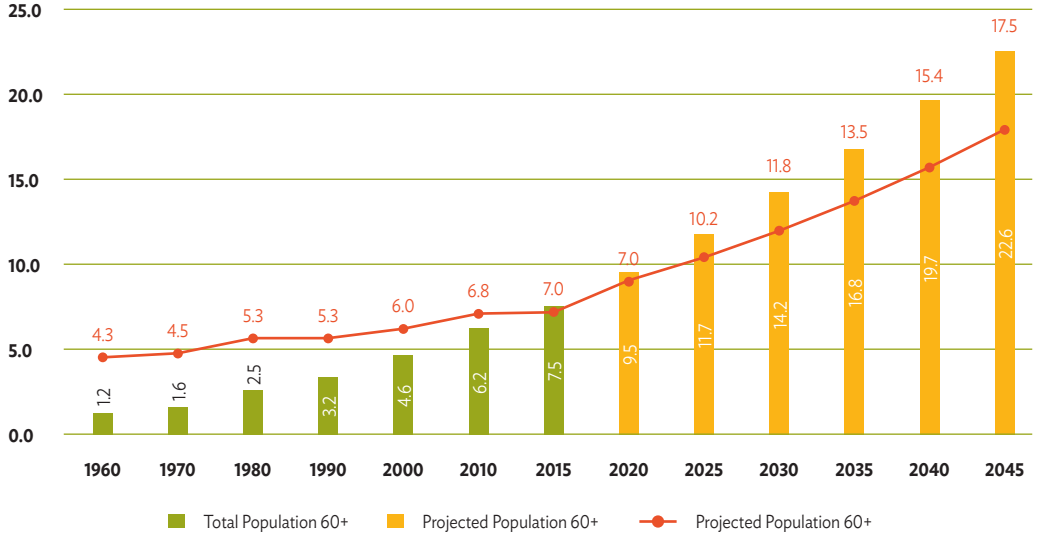
Shelly de la Vega, Juan Antonio A. Perez III and

Lyra Gay Ellies S. Borja

The Philippines is Ageing

Based on the Census of Population (2015), 7.5 million Filipinos were aged 60 years and above or 7% of the total population. Between 2030 and 2035, the population of Filipino older persons is estimated to double in size (Figure 4.1). With its ageing population, the Philippines needs to prepare for the care of older persons.

Figure 4.1. Total Population and Proportion of Population Aged 60 and Over, Philippines: 1960–2004 (millions)

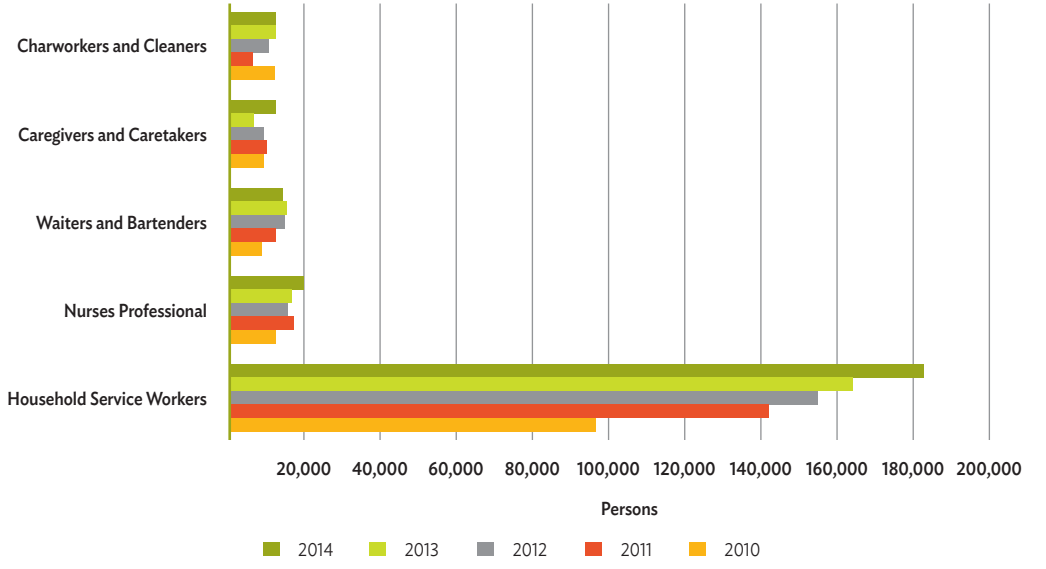


Source: Census of Population and Housing (various years and the low assumption estimates); Philippine Statistics Authority (2015).

Policy and Discourse on Overseas Deployment

The Philippines has become a major source country of domestic care and healthcare workers, sending them to the Middle East, North America, Asia, and Europe. From 2010 to 2014 nurses and caregivers were the top workers deployed to these countries (Figure 4.2).

Figure 4.2. Deployed Land-Based Overseas Filipino Workers by Top-Five Occupational Categories, New Hires: 2010–2014



Source: 2010–2014 Overseas Employment Statistics (Philippine Overseas Employment Administration, n.d.).

Healthcare workers deployed abroad include physicians, physical therapists, occupational therapists, speech pathologists, radiologists, medical technicians, and laboratory workers (Philippine Overseas Employment Administration, n.d.; WorkAbroad.ph, n.d.).

Supply and Demand for Caregivers

In light of an ageing worldwide population, an increase in demand for domestic and international caregivers is anticipated. Aside from the traditional markets such as the United States and Canada, rising demand is felt in Europe (Spain); the Middle East (Israel, Bahrain, and Saudi Arabia); and Asia (Japan, the Republic of Korea).

Training of Caregivers

A caregiver is a person who provides, without supervision, in a private household in which the person resides, childcare, senior home support care, or care of the disabled.

The Technical Education and Skills Development Authority (TESDA) is a Philippine government agency that performs the role of standard setting, registration of programs, assessment, and certification, as well as the conduct of monitoring and continuous evaluation of caregiver training programs. Its caregiver course includes training to care for the elderly in its list of 12 modules. As a result of the Economic Partnership Agreement with Japan, it is hoped that Philippine healthcare workers will be recognised and employed.

Dementia Services and Workforce

Dementia is a disease that affects memory, daily function, and personality. Age is a risk factor, with the likelihood of dementia increasing from approximately 1% for people in their 60s to nearly 25% for people aged 85 years and older. About 32% of Filipino senior citizens report symptoms of forgetfulness and confusion (National Institutes of Health and Department of Health Philippines, 2000). No cure is available and at the most severe stages, a patient with dementia will need assistance in activities in daily living such as feeding, bathing, dressing, walking, and toileting. Although home and community-based care is preferred, changing family structures and the huge time and emotional demands on the family make nursing home care a viable option. The total cost of dementia care in the Philippines has been estimated at PHP849.2 million, with PHP321.3 million spent on informal care, assuming that a family member or informal carer spends 1.6 hours per day providing activities in daily living care (Wimo, Winblad, and Jönsson, 2010). The need for caregivers for persons with dementia in the Philippines and the rest of the world is expected to increase in the coming decades.

The Department of Health Philippines does not hold any data on the number of people in the workforce in mental health care but has reported that every regional health unit has at least one health staff member in charge of the mental health program. There is also a gap in health services structure monitoring. For example, there is no database and monitoring of the health workforce for either public or private facilities dedicated to dementia (De la Vega, Garcia, and Torreblanca, unpublished).

A study on dementia services and the workforce in 26 facilities showed that most of the carers were female, with a mean age of 34.2 years. Half the workforce with experience providing care for dementia patients rated the quality of their service 80% and above. Knowledge on the definition and diagnosis of dementia was poor at 27%. Most were willing to receive training (Dela Vega et al., 2018).

There are no specific dementia modules in the TESDA caregiving program. Special courses offered by the academe, specialty medical specialties, and advocacy groups are occasionally available. The World Health Organization Western Pacific Regional Office (2018) has chosen the Philippines as one of two sites for field-testing the Dementia toolkit for community workers in low and middle-income countries.

Recruitment System, Placement Fee

Health workers who wish to be deployed go through recruitment agencies accredited by the Philippine Overseas Employment Administration (POEA). Directly hired health workers must similarly undergo processing by the POEA. The POEA processing fee is US$100 or its peso equivalent, the Overseas Workers Welfare Administration (OWWA) membership fee is US$25 or its peso equivalent, and OWWA Medicare costs PHP900 (Philippine Overseas Employment Administration, 2013).

Some TESDA accredited training centres offer job search and employment services, and a few have direct links with embassies of countries that need caregivers.

Other Concerns

As a geriatrician, the author has encountered several retired and ageing caregivers from foreign countries. Some do not have health insurance or social insurance that will support their old age. Having worked and lived away from family for many years, they have less reliable social support from family members. Home and host countries will need to address the social security needs of these foreign workers (Asher, 2010).

Future Directions

Improved curricular content on aged and dementia care is recommended for all health professional schools and caregiver training courses.

The Department of Labor and Employment has been working on the following measures to advance for the careers and welfare of the Filipino care and healthcare workforce through the following: 1) benchmarking course curriculum and comparability studies and technical cooperation towards signing and implementing mutual recognition agreements (MRAs); 2) promoting welfare, social security, and protection of rights through bilateral dialogues with countries of destination; and 3) implementing the Association of Southeast Asian Nations (ASEAN) Qualifications Reference Framework and MRAs on seven priority professions, including nursing.

Other considerations may include 1) inter-regional dialogue on long-term care (ASEAN and East Asia); 2) a coalition of sending countries to work with receiving countries (Indonesia and Philippines vis-à-vis Hong Kong, for example); and 3) legislation for a whole-of-nation approach to fast ageing (Perez, 2018).

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CHAPTER 5

Sending More or Sending Better Care Workers Abroad? A Dilemma of Viet Nam's Labour Exporting Strategy

Khuat Thu Hong

Whilst international labour emigration from Viet Nam started a long time ago, it was only in the early 1990s that it became part of the government's socio-economic development strategy. After about 2 decades of efforts to increase the number of workers sent abroad, the government has recently shifted its focus to their quality. Sending professionally trained care workers or carefully selected candidates for care jobs to developed countries such as Japan or Germany is part of the new strategy. However, it turned out easier said than done. The programme faces numerous issues and challenges, regardless of strong government support.

Before describing how care workers are recruited, trained, and sent abroad, this chapter provides a brief chronology of international labour emigration in Viet Nam. The third section outlines key features of the governance of labour export and regulations on the care worker programme.

Brief History of International Labour Migration in Viet Nam

The first recorded international labour migration from Viet Nam took place at the end of the 19th century. On 12 March 1891, 791 Vietnamese, of whom 50 were women, landed in Nouméa (New Caledonia), sent by French colonists to work in mines and plantations.

Figure 5.1. Recounting the History of the Diaspora of Vietnamese Contract Workers

Note: 1938. Rally of Vietnamese hired workers on a plantation in the New Hebrides during the visit of the Inspector of Colonial Labor.

Source: Photo collected by J. Vanmai, 1991. http://jeanvanjeanchandang.blogspot.com/2018_10_03_archive.html

Note: Labour recruiting agency in Hai Phong 1920.

Source: Photo collected by J. Vanmai, 1991. http://jeanvanjeanchandang.blogspot.com/2018_10_03_archive.html

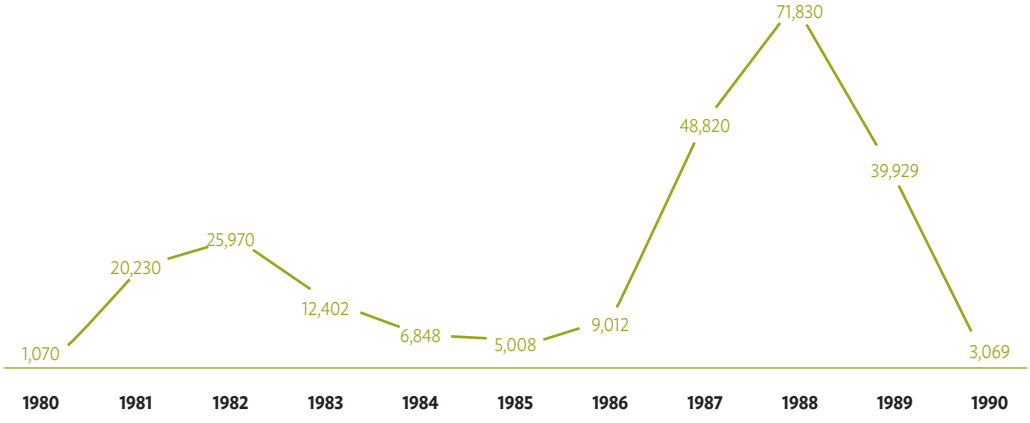
Except those who were exiled prisoners, 41 were contracted workers or chân đăng (literally, registered foot) on 5-year contracts. The men worked in the nickel or chrome mines and the women on plantations. The average monthly salary was equivalent to FRF12 for male workers and FRF9 for females, 30 times higher than the average salary in Viet Nam at that time (Vanmai, 1991; Brou, 1980). By 1940, about 20,000 Vietnamese had been sent to work in New Caledonia and Vanuatu.

The second wave of labour migration from Viet Nam occurred in the 1980s and 1990s, when labour export became official government policy (Anh, 2008). The primary objectives of the programme were to improve Vietnamese workers' skills for the country's future industrialisation and to increase the income of part of the labour force. Labour export was based on the cooperation between Viet Nam and the receiving countries through government and sector agreements. The state directly sent workers and experts to work abroad. In 1980–1990, a total of 277,183 workers were sent to work in the socialist bloc, including 112,338 to the Soviet Union, 72,786 to East Germany, 37,659 to Czechoslovakia, and 35,099 to Bulgaria (Schwenkel, 2014). The labour cooperation programme was implemented to pay Viet Nam's mounting debts to these countries and was ended when the socialist bloc disintegrated in the 1990s.

Viet Nam sent experts and workers to several countries in the Middle East and Africa. In 1983–1984, 5,301 experts were sent to Libya, Algeria, Angola, Mozambique, Congo, or Madagascar, and about 14,000 to Iraq (DOLAB, 2005).

The Gulf War and the collapse of the socialist bloc led to the nullification of the labour treaties. Most Vietnamese workers in the former Soviet Union, Eastern Europe, the Middle East, and Africa returned to Viet Nam before their contracts ended. On 13 March 1990, the government's Directive No. 73-CT put the labour export programme on hold (ASEAN, 2017).

Figure 5.2. Number of Vietnamese Workers in the Soviet Union and Eastern Europe, 1980–1990



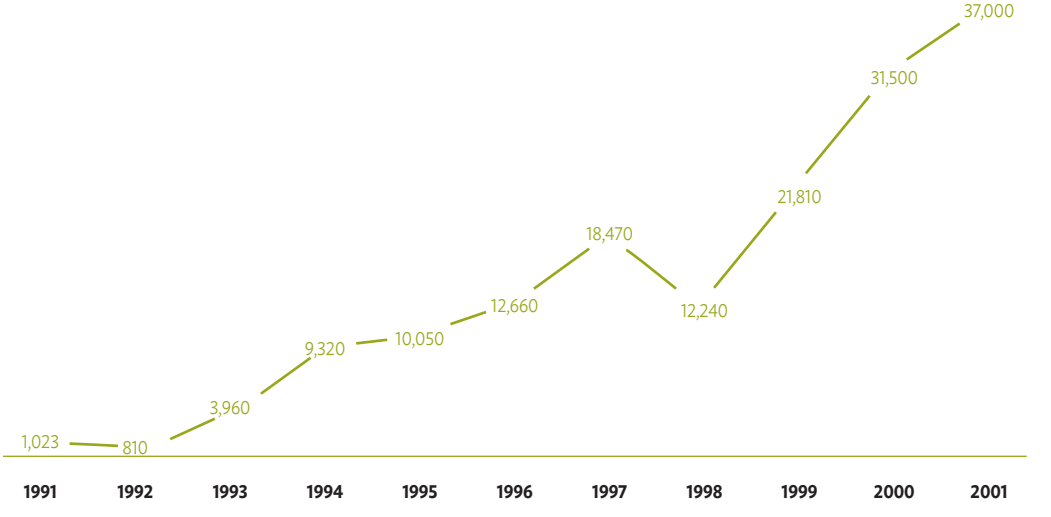
Source: DOLAB (2005).

Figure 5.3. Vietnamese Workers in East Germany, 1985

Vietnamese workers in East Germany, 1985. (Photo: Friedrich Hibeck, 1985.)

The third wave of international labour migration from Viet Nam started at the beginning of the 1990s. Labour export was an important socio-economic development in the Doi Moi era[1]. The major destinations were developed countries in Asia such as Taiwan, the Republic of Korea, Japan, and Malaysia, and in the Middle East, including Iraq, Kuwait, the United Arab Emirates, and Saudi Arabia (Anh, 2008). At the beginning of the 1990s, Viet Nam sent only about 1,000 workers abroad per year. The number had increased by 20 times, to 21,800 workers in 2000.

Figure 5.4. Number of Vietnamese Workers Overseas, 1992–2001



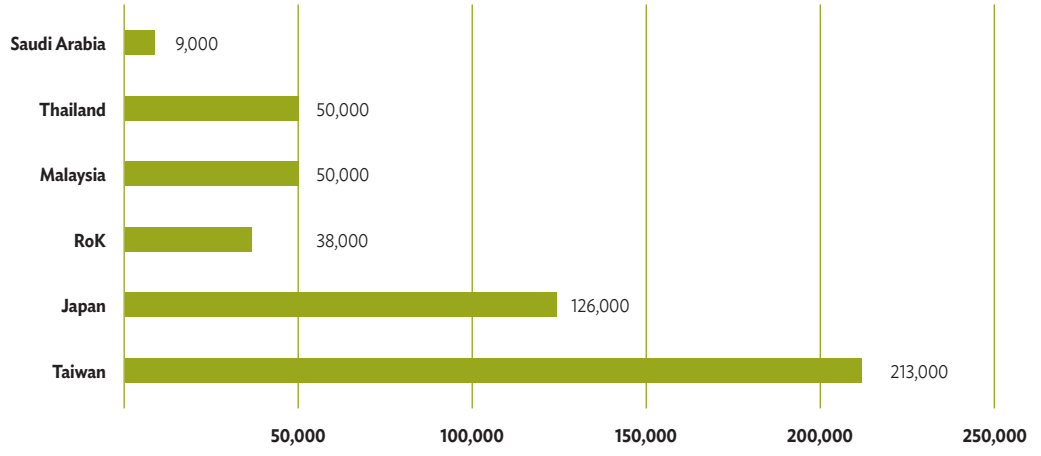
Source: DOLAB (2005).

[1] *Doi Moi* (Renovation) refers to the economic reforms initiated in Viet Nam in 1986 to transition it from a command economy to a socialist-oriented market economy.

Since 2010, the number of Vietnamese workers sent abroad has steadily increased. On average, in the first half of the 2000s, it reached 80,000 per year and, in 2014–2019, exceeded 100,000 per year (Hong, 2018).

The diversity of destinations is remarkable. Besides the traditional destinations such as Taiwan, the Republic of Korea, Japan, and Malaysia, significant flows of Vietnamese workers go to Thailand, the Lao People's Democratic Republic, Europe, the Middle East, and others. There are more than 560,000 Vietnamese workers in 43 countries and territories worldwide, in manufacturing, construction, fishing, agriculture, domestic work, and services. The Department of Overseas Labour (DOLAB) estimated that, by March 2019, there were 170,000 Vietnamese workers in Taiwan, 148,000 in Japan, 50,000 in the Republic of Korea, 50,000 in Malaysia, and 50,000 in Thailand (ILO, 2020).

Figure 5.5. Estimated Total Number of Vietnamese Workers in Major Destination Countries by June 2018



RoK = Republic of Korea.

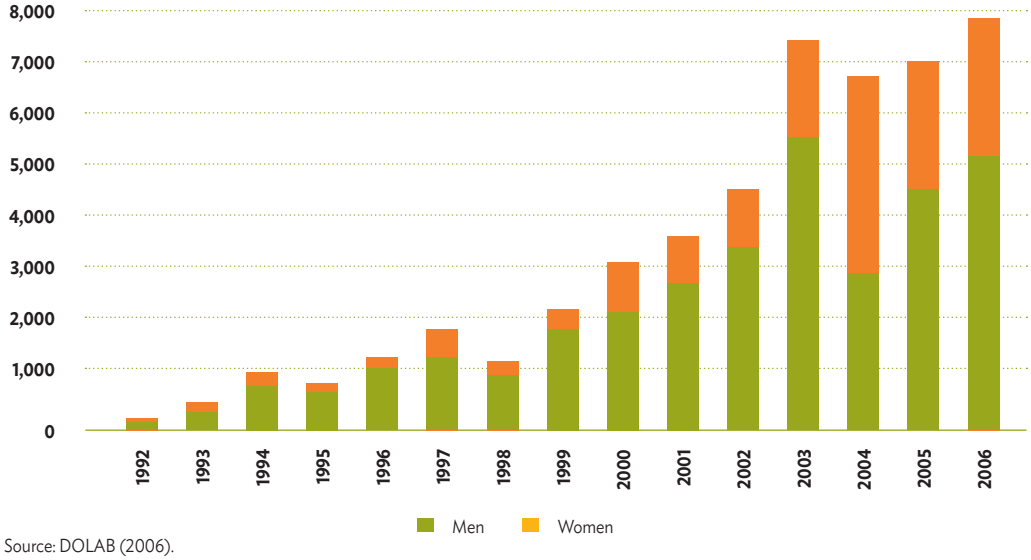
Source: Author, based on DOLAB (2018).

On average, a Vietnamese worker in Taiwan earns US$650 a month, in Japan US$1400, in Republic of Korea US$1,000, in Malaysia US$300, and in Saudi Arabia US$320 (IOM, 2016).

Viet Nam first sent workers to Japan in 1992. By 2010, the total number was 52,000, mainly under the Japanese Industrial Training Program and the Technical Internship Program. They were employed mainly in manufacturing, construction, agriculture, and fishery (Ishuzuka, 2013). Viet Nam has so far sent more than 200,000 workers to Japan, surpassing China in number of workers sent abroad annually and surpassing 15 countries in number of trainees in Japan (MOLISA, 2019)

A clear tendency of feminisation has been observed in international labour migration from Viet Nam. Figure 5.6 and the Table 5.1 show that the proportion of female workers increased to almost 40% from the early 1990s to 2018.

Figure 5.6. Vietnamese Workers Overseas, by Sex, 1992–2006



Source: DOLAB (2006).

Table 5.1. Vietnamese Workers Overseas, by Sex, 2006–2018

Year	Number of Workers		Year	Number of Workers	
	Total	Female		Total	Female
2006	53,855	27,023	2013	88,155	31,769
2007	85,020	28278	2014	106,840	40,063
2008	86,990	28,598	2015	115,980	38,640
2009	73,028	22020	2016	126,296	46,029
2010	85,546	28,573	2017	134,751	53,340
2011	88,298	31,990	2018	142,860	50,293
2012	80,320	27,784	2019	152,530	54,700

Source: VAMAS (2018)

International labour migrants contribute significantly to Viet Nam's economic development through remittances. According to National Assembly's monitoring report on labour export, Vietnamese workers abroad send home about US$2 billion–US$2.5 billion a year, with an average increase of 6%–7% per year in 2010–2017 (MOLISA, 2019).

Viet Nam is a major source of unskilled labour for high-income countries in East Asia (Ishuzuka, 2013). There is concern that the government's promotion of international labour migration to reduce poverty, which targets poor people, including ethnic minorities with limited education, encourages the most vulnerable to migrate (ILO, 2019). The policy deviates from the Communist Party's and government's initial intention of developing a skilled workforce to industrialise and modernise Viet Nam. The government is trying to pursue the original goal by increasing the proportion of skilled labour amongst workers overseas.

On 8 March 2017, in Ha Noi, the Ministry of Labour, Invalids and Social Affairs (MOLISA) held a conference on improving the quality of overseas Vietnamese contract labourers. Various high-ranking leaders of the Communist Party, the government, and the National Assembly attended, as did representatives of more than 200 enterprises that dispatch workers to work overseas. In his opening speech, the minister of MOLISA stressed that the policy of the Communist Party and the state was to boost labour export, not only to solve unemployment and reduce poverty but also to promote decent work and thereby mobilise resources for economic development. To improve the quality of labourers working overseas, MOLISA will reform labour export programme. Key tasks are expanding the proportion of labourers with technical and professional qualifications to work abroad, and improving the quality of labourers' vocational training, foreign languages, and awareness through the pre-departure course. Sending qualified care workers to high-income countries such as Japan, Germany, and Taiwan is seen as an important measure to implement the tasks (MOLISA, 2017).

Figure 5.7. Popular Poster in Rural Area

Note: Text in poster stated: 'To escape poverty, join international labour export'.
Source: Photo by Pham Quang Hoa.

Care Worker Programme

As defined by the International Labour Organization (ILO), care workers tend to the most basic human needs and sustain the well-being of those who are in a dependent position (ILO, 2018).

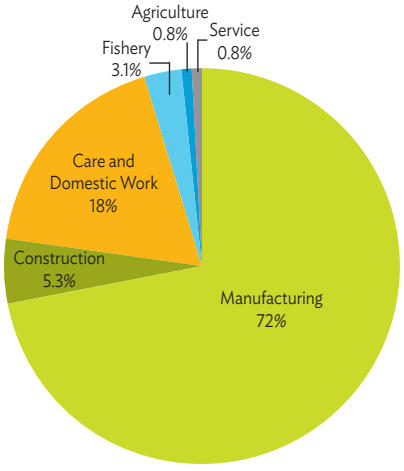
In this chapter, 'care workers' include domestic workers and/or housekeepers and workers who care for people who are ill, disabled, or have special needs. A care worker might have no professional training in care work or be professionally trained as a nurse or assistant nurse.

Recruitment System, Fees, Training, and Placement

Family and Hospital Vietnamese Care Workers in Taiwan

Taiwan is the first destination of care workers (housekeeper or domestic workers and care workers for people with special needs) from Viet Nam. The programme started in 2000, was suspended in 2005, and resumed in 2015 (ASEAN, 2015). Vietnamese workers are home and hospital care workers. Neither group has professional training for care jobs, but both have basic caring skills learned during pre-departure training.

Figure 5.8. Types of Jobs Vietnamese Workers Hold in Japan, the Republic of Korea, Malaysia, and Taiwan



Source: MOLISA (2012).

By 2012, Vietnamese domestic workers and care workers accounted for 18% of total workers sent abroad, with most working in Taiwan (Figure 5.8).

By 31 August 2018, the total number of Vietnamese care workers in Taiwan was 13,600 person-times, an increase of 10 times from 500 person-times in 2015 to 5,200 person-times in 2016, which slightly increased in the following years (DOLAB, 2018).

There are no specific recruitment criteria for care work in Taiwan. Women under the age of 50 years are eligible for family care work. If the employer renews the contract, women older than 50 are eligible.

The recruitment fee for a hospital care worker in Taiwan is US$3,300, and for a family care worker US$2,036. These amounts are perceived as reasonable.

Figure 5.9. Pre-departure Training for Care Workers to Taiwan

Source: Photo by Cong Ty Thinh Long, 17 March 2018.

The selected candidates must undergo 390 hours of compulsory training:

(i) 90 hours for technical training,

(ii)100 hours for local legal regulations and basic living skills, and

(iii) 200 hours for language.

In principle, family and hospital care workers' first contract term is 3 years but can be renewed up to 14 years if the worker has a good reference from a previous employer.

As of 1 January 2018, the monthly salary for a hospital care worker was NT$22,000 (US$700) and for a family care worker NT$17,000 (US$500).

Annual leave regulations have recently been amended in favour of employees. Care workers who work consistently for one employer enjoy 3–30 days or more of annual leave. The timing of leave is the employees' choice. Employees are paid their full-time salary for annual leave. Employers reimburse employees for unused annual leave when the contract expires or the year ends.

Care Worker Programme for Japan

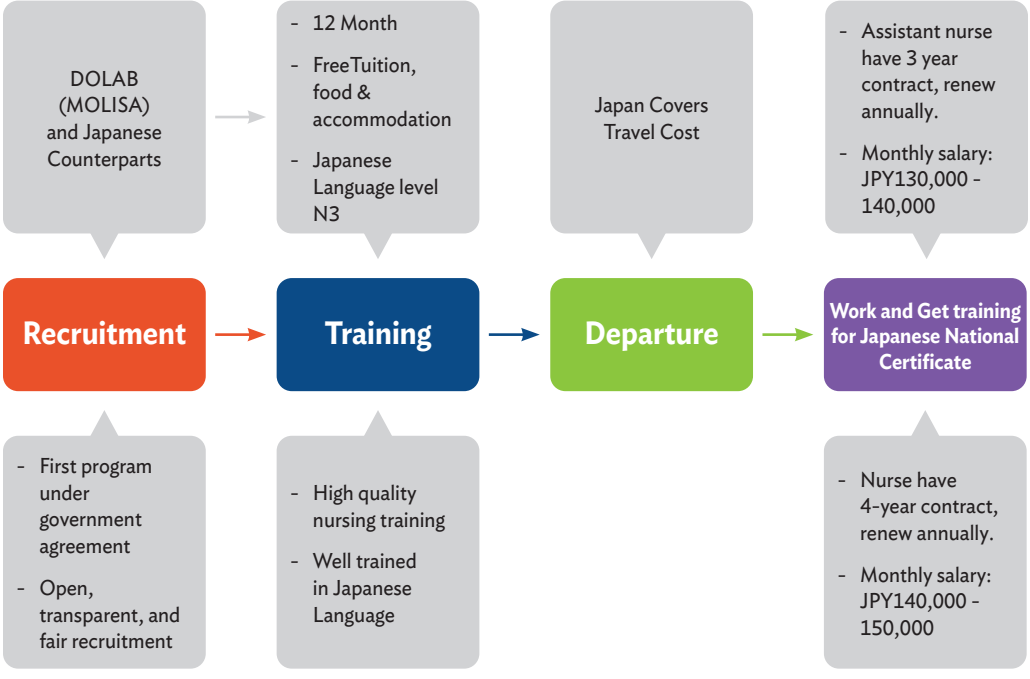
The first programme to send Vietnamese care workers to Japan was initiated under the Vietnam–Japan Economic Partnership Agreement (VJEPA), which was signed in 2012. To meet Japan's strict requirements, MOLISA has assigned the Department of Labour Overseas (DOLAB) to collaborate with Japan's Social Welfare and War Victims' Relief Bureau, Ministry of Health, Labour and Welfare on developing regulations on nursing interns from Viet Nam to ensure compliance with the laws of both countries.

In 2018, after the success of the first batches of care workers under the VJEPA, the second programme, for skill internship, was launched under the memorandum of cooperation (MOC) between the two countries, signed on 6 June 2017, which became effective on 1 November 2017.

1) Recruitment, Training, and Placement of Vietnamese Nurses and Assistant Nurses under the Vietnam–Japan Economic Partnership Agreement

The recruitment process and criteria for nurses (看護師) and assistant nurses (介護福祉士 or 介護士) to work in Japan are much more stringent than for care workers going to Taiwan. DOLAB exclusively manages the entire VJEPA nursing programme (Figure 5.10).

Figure 5.10. Recruitment, Training, and Placement of Nurses and Care Workers for Japan



DOLAB: Department of Labour Overseas, MOLISA: Ministry of Labour, Invalids and Social Affairs.

Source: MOLISA (2015).

While recruitment and training are similar for nursing and assistant nurse candidates, the two categories differ slightly in qualification requirements, terms of contract, and salary.

The nursing candidate must be 35 years old or younger and have graduated from nursing college (3 years) or general nursing university (4 years). The candidate must submit a certificate of good health from a medical agency designated by the Ministry of Health and proof of having no criminal record. Important requirements include a medical practice licence in accordance with the Law on Medical Examination and Treatment and proof of at least 2 years of nursing experience. A nursing candidate is offered a monthly salary of JPY140,000–JPY150,000 in Japan. The term is 4 years and can be extended to 5 years or longer.

Like nursing candidates, assistant nurse candidates must meet age, health, and criminal record requirements but do not need to have a medical practice licence or 2 years of working experience. They are offered a 3-year contract, with a monthly salary of JPY130,000–JPY140,000.

Selected candidates in both categories undergo a 12-month training course on Japanese language to obtain level N3. Tuition, food, and accommodation are covered by the Japanese side. Only trainees who achieve Japanese language level N3 are sent to Japan, where they continue to study for the Japanese national nurse or assistant nurse certificate and Japanese language level N3.

In 2012–2018, to ensure open, transparent, and fair recruitment, DOLAB, in cooperation with its Japanese counterparts, directly recruited candidates for the programme.

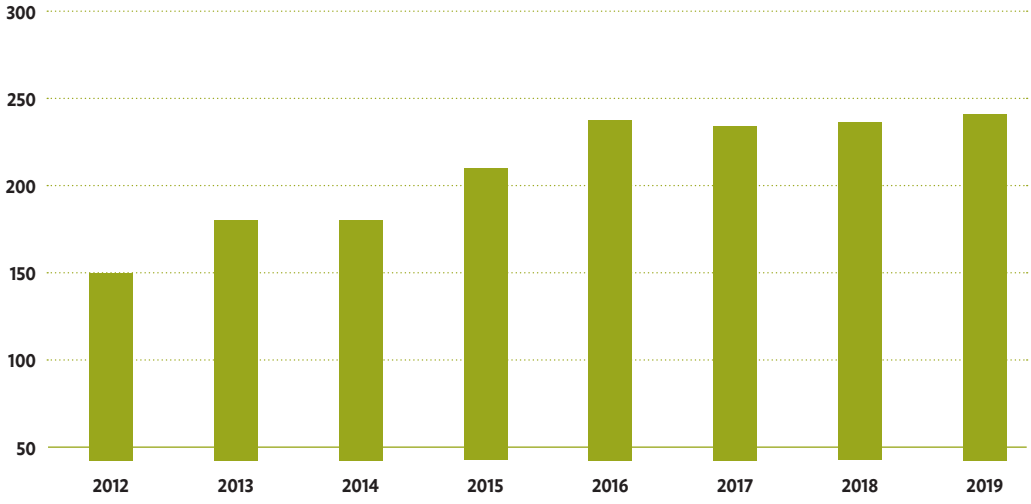
According to information from the mid-term workshop to evaluate the VJEPA nursing programme, organised by MOLISA on 12 November 2020 in Ha Noi, in 2012–2019 a total of 1,610 candidates, mainly females, were selected for eight Japanese language training courses. Of the candidates, 1,340 were sent to work in Japanese hospitals and healthcare facilities (Chau, 2020). Figure 5.11 shows the number of nurses and assistant nurses dispatched to Japan under the VJEPA.

2) Skill Internship Program for Care Workers under the Memorandum of Cooperation

On 6 June 2017, the minister of labour, invalids and social affairs of Viet Nam and the minister of health, labour and welfare of Japan signed the MOC on the Skill Internship Program, which became effective on 1 November 2017. Specific terms on care worker internship in Japan were agreed and signed by both sides on 3 August 2018, during the visit to Tokyo of the MOLISA deputy minister.

The skill internship programme requirements under the MOC are not as high as those under the VJEPA. Candidates must graduate from at least high school. Once selected, candidates study Japanese language in Viet Nam and basic nursing and care work skills for 4 or 5 months. Those who earn Japanese language level N4 before departure are offered a minimum 3-year contract, which can be extended to 5 years maximum (Japan.net.vn, 2020).

Figure 5.11. Number of Nurses and Care Workers Dispatched to Japan under the Vietnam–Japan Economic Partnership Agreement

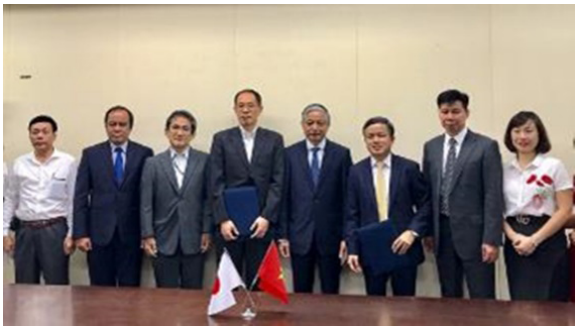


Source: Nguyen (2020).

Under the MOC, the Japanese supervisory unions cover tuition fees for language training up to level N4 before the interns depart. Once interns arrive in Japan, the Japanese supervisory unions and recipient agencies are responsible for language and occupational training needed by interns to pass the examination after the first year of the internship. Supervisory unions pay the management fees of dispatching agencies throughout the internship programme in Japan (DOLAB, 2018).

On 1 June 2018, a MOLISA decision allowed six labour export agencies to recruit care worker candidates to pilot the internship programme. In the same year, MOLISA granted licences to seven more labour export agencies in southern Viet Nam to join the MOC programme.

Figure 5.12. Representatives of Viet Nam and Japan at Signing Ceremony



Note: Representatives of Viet Nam and Japan at the memorandum of cooperation signing ceremony, 3 August 2018.
Source: Photo by Department of Overseas Labour.

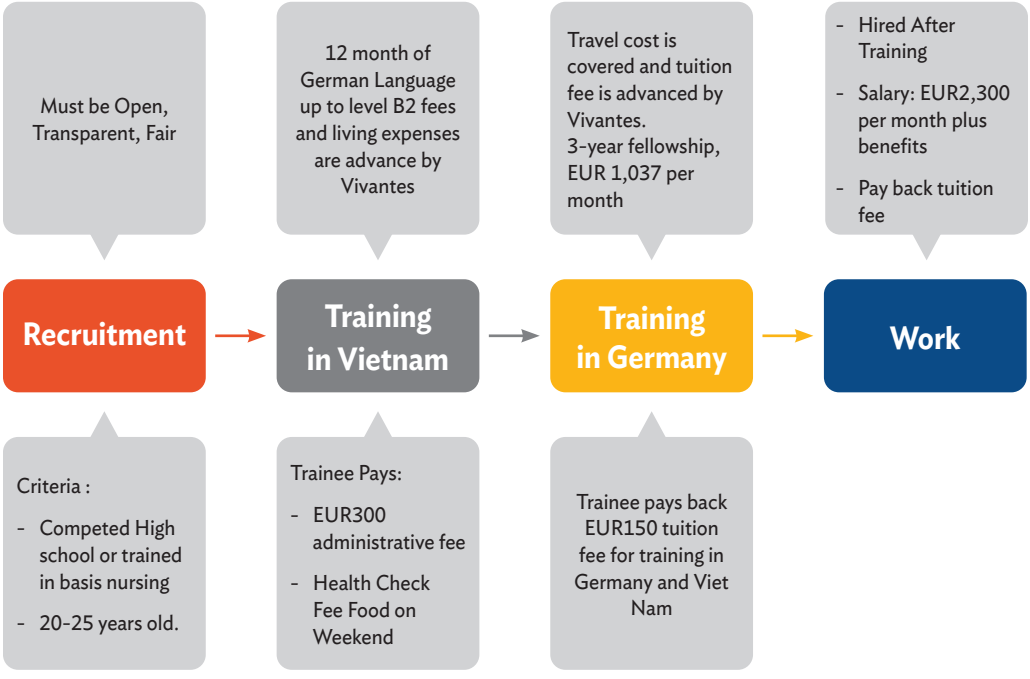
3) Care Worker Programme for Germany

This programme is based on the Letter of Intent signed between MOLISA and Germany's Ministry of Economics and Energy on 1 July 2015 (The representative offices of the Federal Republic of Germany in Vietnam, 2018) The parties agreed on basic principles of fair recruitment for training in the care of the elderly in Germany. MOLISA has assigned the Centre of Overseas Labour (COLAB) to collaborate with receiving agencies in Germany to recruit, train, and send Vietnamese care workers to study and work in Germany (MOLISA, 2015). Since 2017, Germany has received 100 trainees from Viet Nam every year.

COLAB and Vivantes, a German company, agreed to jointly recruit, train, and send Vietnamese students to Germany for a nursing training programme. Like the care worker programme for Japan, the German programme emphasises openness, transparency, and fairness. The first training course was launched on 21 July 2016 (MOLISA, 2016). The first piloting training programme was launched in 2013 (MOLISA, 2013).

The recruited candidates are provided free training in German language for 12–18 months at the COLAB training facility. Training courses start on 1 August annually, delivered by the Goethe Institute in Ha Noi. Students who pass the exam are granted a certificate of German degree B2.

Figure 5.13. Recruiting, Training, and Placement of Care Workers in Germany



Source: Based on the Letter of Intent signed on 2015 between MOLISA and Germany (The representative offices of the Federal Republic of Germany in Viet Nam, 2018).

After language training, students attend a nursing training programme in Germany for 3 years. They are granted a German national certificate and offered a working contract in elderly care centres. Figure 5.13 summarises recruitment, training, and placement of Vietnamese care workers.

Since the programme started in 2013 until the end of 2019, it has sent 600 trainees to Germany for study and work (MOLISA, 2019).

Challenges and Issues of Care Worker Programmes

Although the care worker programmes, particularly for Japan and Germany, are strongly supported by the governments of Viet Nam and the receiving countries, they are not necessarily the most attractive option for Vietnamese who intend to work abroad.

Traditionally, caring for the elderly or sick was not seen as an occupation in Viet Nam. In the past, only poor or low-status people accepted such work. It is still considered difficult and demeaning. However, as Viet Nam's ageing population grows, demand for care work is also increasing. A professionally trained nurse and assistant nurse can easily find a well-paying dignified job in Viet Nam. In 2019, in the big cities such as Ha Noi and Ho Chi Minh City, depending on the severity of the patient's illness, an untrained care worker can earn VND2500,000–VND500,000 a day (Hoai, 2019). Therefore, not many see care work abroad as desirable:

> Demand for care workers in Taiwan is very high. However, supply from Viet Nam is still insufficient. Many people are not willing to do such a hard job whilst being far from home. Domestic demand is also high. (Interview with Mr. Pham Lan, deputy director of Techsimex, a labour-recruiting company.)

Many people find the stringent recruitment criteria of Japan discouraging. The language barrier is significant. Expensive living costs are an important factor for consideration (Ngoc, 2014).

Limits on overtime work for nurses or assistant nurses are another reason that Japan is unattractive:

> Overtime pay is quite high, usually JPY753 per hour (in rural areas), but a nurse or assistant nurse is allowed only 2 hours overtime work a day. It is difficult to improve one's income. (Interview with a Vietnamese nurse working in Japan.)

In addition to the high professional requirements, the Japanese care worker programme's age requirement makes it less attractive to many. Since care work is still largely considered women's work, the age criterion of 35 or younger might exclude many potential female candidates. The average marriage age is 23.1 (GSO, 2019) and most Vietnamese women marry from ages 20 to 25 and have children within the next 10 years. Since marriage and family are still a central value in Vietnamese society, especially for women, many women choose to stay in Viet Nam

to get married and have children instead of going to work abroad. Even if Japan loosens its immigration policies and increases work incentives, it will be difficult to keep trained care workers for a long time. The age requirement for care workers in Taiwan is not as strict. Many women can work abroad at age 40 or older because they have already had and brought up their children and can be away for a long time. Some nursing students at Ha Noi Medical University shared that they found the programme to work in Japan attractive but did not want to go for fear that they would be past marriageable age when they returned.

One important challenge to the programme is the widespread illegal labour brokering, which often involves deception in many areas across Viet Nam. Numerous newspaper articles report fake brokering. DOLAB has warned that agencies and individuals use various tricks to cheat those who want to work abroad, such as setting up fake websites to recruit care workers to Japan and Germany or pretending to be government officials from a recruiting agency (Hung, 2017).

Nhan Dan, an online newspaper, reported on 4 July 2007 that, in 2006–2007, Ha Noi police discovered and cracked down on 71 fraud cases related to labour export. As many as 2,118 people were deceived and cheated of nearly VND50 billion, including VND14.5 billion and US$2,354,300.

Tin Tuc, another online newspaper, warned that some brokering agencies and individuals had approached nursing colleges and vocational schools to deceive students with dubious advertisements and counselling about recruitment of care workers to Japan and had collected money from the students (Xuan, 2015).

High brokerage fees due to poor management and control of recruitment is another challenge. Although DOLAB directly recruits care workers for Japan and Germany, some individuals and companies openly recruit and collect money from many who have just graduated from universities and medical colleges (Phong, 2014). Stories of people cheated by brokers discourage many from considering work abroad. For example, the fraudulent recruiting agency allows the recruit to pay the fee in small amounts over time, creating the illusion that the fee is not as high as it is. The programme does not require a deposit, but many recruiting agencies still take money from workers, as much as VND100 million or even more.

Some recruiting agencies even encourage run-away workers to persuade other workers to run away, too, so that the agencies can confiscate their deposit money. Some fake brokers tell unsuccessful applicants that they were selected, then take their money. Applicants pay the full fee, then they are told that the receiving company has not accepted them because their records are problematic (JVNET, 2017).

Numerous newspapers and research papers report that the multi-layered brokerage network has led to high pre-departure costs. A female worker going to Japan shared that she paid a large amount of money to an agency, which she now suspects is cheating her by creating a multi-layered selection and recruitment process to take more money from candidates: 'To go to Japan, I had to spend few hundred million dong for training fees, health check, visa, and other expenses' (interview).

Governance of International Labour Emigration

Overview of Labour Export Legislation and Policies

Since Doi Moi, labour export has been an increasingly important socio-economic development strategy of the Communist Party and the government. Over the last 3 decades, various policies and regulations have been passed to regulate labour export and to improve legislation.

The first of the policies was Decree 370-HDBT, 9 November 1991. It set mechanisms for licenced economic enterprises to secure contracts with foreign companies to recruit, train, and dispatch Vietnamese workers to work abroad for a fixed period.

In 1995, the decree was replaced by Decree 07-CP, which has detailed provisions based on the Labour Code on sending workers to work abroad for a fixed period.

In 1998, the Politburo passed Directive 41-CT/TW on labour export, emphasising that 'labour export is an important and long-term strategy, contributing to building a workforce for the construction of the country during the period of industrialisation and modernisation and is part of international cooperation, contributing to strengthening friendship and long-term cooperation with other countries' (Communist Party of Viet Nam, 1998). The directive says that 'exporting labour and specialists must be expanded and diversified'. Besides improving enterprises specialising in labour export, the directive encourages expanding the areas of state-owned enterprises eligible for direct labour export in the form of bidding for contracts, sending workers to work in foreign enterprises, encouraging enterprises and individuals working abroad to seek jobs, and attracting more workers from home.

The directive allows non-state enterprises, particularly those of mass organisations such as the Viet Nam General Confederation of Labour, Communist Youth Union, and Vietnamese Women Union, to export labour under the close management of the mass organisations and the state.

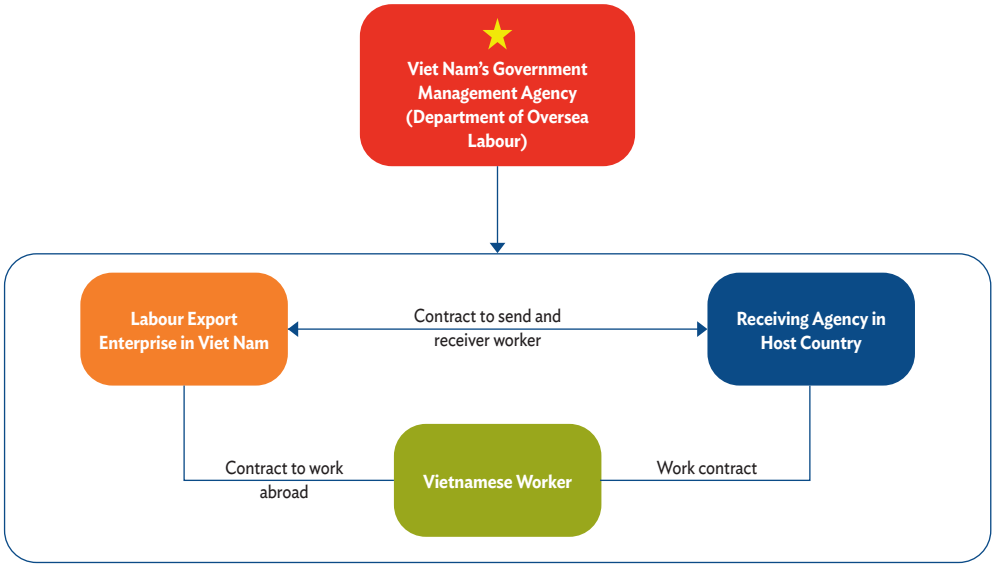
To implement the Communist Party's directive, on 20 September 1999, the government issued Decree No. 152/1999/ND-CP, allowing enterprises of all mass organisations to export labour. This has led to the booming of various types of enterprises involved in labour export and the rapid increase in the number of workers overseas, thus indirectly causing chaos in recruiting and dispatching workers (Government Viet Nam, 1999).

The Law on Contract-Based Overseas Workers, adopted by the Eleventh National Assembly on 29 November 2006, provides the overarching framework governing international labour

migration. Nevertheless, many undocumented migrant workers are employed irregularly outside the bilateral agreement and memorandum of agreement on labour migration in China, Thailand, Russia, the Lao People's Democratic Republic, and a few other countries. A rising number of Vietnamese workers are overstaying their visas and work illegally in the Republic of Korea and Taiwan. Irregular migration is punishable by fines and other sanctions in Viet Nam and the destination countries (ILO, 2018).

To help migrant workers better adapt to their work and life in the hosting countries and prevent the workers from running away or overstaying, MOLISA issued Decree No. 18/2007/QĐ-BLĐTBXH on 18 July 2007, instructing recruitment agencies, including private enterprises, to provide a compulsory 72-hour pre-departure training programme for workers. Decree 144/2007/ND-CP stipulates regulations on sanctioning administrative violations in sending Vietnamese workers abroad.

Figure 5.14. Labour Export Process



Source: MOLISA, 2008.

As it has adopted labour migration as an important poverty reduction strategy, in 2008 the government approved a project for 2009–2020 to help the poorest districts facilitate working overseas. The Prime Minister's Decision 71, 2009, approved continuing the project. The project's objective was to send 120,000 poverty-stricken workers abroad from 2009 to 2020. As result, the residents of poor districts in 20 provinces, who have contracts for work overseas, are eligible to apply for subsidies to facilitate working overseas. The incentives include loans and financial assistance for language training, vocational skills training, health checks, and other services (Government of Viet Nam, 2009).

To regulate the management, operation, and use of the database on workers sent abroad under contract, MOLISA promulgated Circular 35/2017/TT-BLDTBXH, which came into effect in February 2018 and includes provisions for licensing recruiting agencies, information on recruitment agencies, and reporting mechanisms for Vietnamese overseas workers. To improve the process of sending workers abroad, MOLISA adopted more stringent regulations and conditions to ensure that only enterprises that meet the law's requirements can dispatch labourers to work abroad. A list with the names and contact information of enterprises is on the DOLAB website. By the end of 2020, 487 enterprises were licenced to recruit and send workers abroad. The website lists the enterprises sanctioned for administrative violations, with financial punishment or suspension of activities (DOLAB, 2021).

Regulations and Policies on the Care Worker Programme

There are no separate regulations on recruiting and dispatching home or hospital care workers to Taiwan. They are recruited in the same way as other workers, except that they might receive short basic training on caring skills before departure. Although they will care for the elderly or the sick, they are not required to submit proof that they are professionally trained as a nurse or assistant nurse to be eligible for recruitment. The language requirement is basic. The workers are recruited and dispatched to Taiwan through state-owned or private companies. Many even go to Taiwan through personal connections, introduced by relatives or friends there.

Regulations for care workers for Japan are different. Recruitment under the VJEPA nursing programme is exclusively coordinated and managed by DOLAB. Recruitment takes place once a year and is announced on the MOLISA website and in most popular mass media (Phuong, 2015).

Requirements for nursing candidates under the VJEPA are stringent. Candidates must have already been trained in a nursing college or university. After selection, they must study Japanese language for 12 months to achieve level N4 before going to Japan. Nursing candidates must have at least 2 years of experience in nursing work and have a medical practice licence.

The MOC on the skill internship programme opened opportunities for labour exporting agencies. Key provisions include extending the skill training period in Japanese from 3 to 5 years, increasing the number of trainees admitted to Japan, granting licences to Japanese supervisory unions to receive interns, establishing Organization for Technical Intern Training (OTIT) – an agency to administer the skill internship programme, approving the skill internship plan, and setting up criteria for sending organisations. The MOC requires companies that send trainees to Japan to not withhold trainees' deposits, publicize the fees that trainees must pay to avoid overcharging and violating regulations of Viet Nam, and reduce some Japanese administrative paperwork for workers. The MOC stipulates the responsibilities of Vietnamese and Japanese agencies: the Vietnamese side examines and introduces Vietnamese enterprises that meet requirements of the internship programme, and the Japanese side licences the Japanese management organizations and approves the plan to receive Vietnamese interns according to the MOC provisions specified. To implement the MOC, MOLISA has permission from the Prime Minister to select 30–50 qualified companies to take part in the care worker internship programme. In 2018, MOLISA granted licences to 13 companies (DOLAB, 2018).

In 2019, the Centre of Overseas Labour was assigned to cooperate directly with the Osaka Medical Care Association (Japan) in sending care workers for internship to Japan (COLAB, 2019).

Conclusion

After decades of implementing a massive labour export programme with a large number of low-skilled workers, Viet Nam has realized that it must improve the quality of its workforce to increase incomes and improve the national brand. The growing demand for caregivers in developed countries is an opportunity for Viet Nam to do so. However, the way forward is not easy.

The success of the care worker programme is not dependent on the strong political will of Vietnamese leaders or efforts to win elections by leaders in the host countries. The deciding factors are individual worker considerations and cultural barriers, psychological stresses, and professional requirements. Even though care has gone beyond the family and even national borders to become a global issue, it is still largely considered women's work. The programme is designed to ignore social expectations of women's role in the family and community. It is difficult and perhaps unfair to expect women to leave their caring role in their own families to take that role elsewhere while social institutions and perceptions remain unchanged.

Viet Nam, however, is starting to age rapidly. In the next 20 years, people aged 65 and over are forecast to account for 20% of the population (GSO, 2020). The need to care for the elderly in Viet Nam will increase. It is not ready to meet its own care needs. The current ratio of nurses per doctor is 1.5; the World Health Organisation (WHO) standard is 4.0 nurses per doctor. There are only 140,000 nurses nationwide and it is forecast that, by 2023, Viet Nam will face a shortage of as many as 50,000 nurses (Nhan Dan, 2020). Policymakers are concerned about balancing domestic and international demand. Mr. Pham Do Nhat Tan, former director of DOLAB and currently vice-chair of Vietnam Association of Manpower Suply (VAMAS), expressed his concerns in an interview:

> For example, due to the large number of its workers abroad, the Philippines country is facing a serious shortage of labour for the domestic market. As about 80% of nurses and assistant nurses are working abroad. The country has to increase salaries and improve other benefits to limit the outflow of nurses. Our programme of sending care workers abroad should follow a reasonable trajectory to balance domestic demand and the potential of the international market.

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