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Care in Malaysia:
Emerging Trends, Challenges and Opportunities

Ilyana Mukhriz, Hafiz Hafizi Suhaimi and Hawati Abdul Hamid

Khazanah Research Institute

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Authors' email address: **ilyana.mukhriz@krinsitute.org, hafiz.suhaimi@krinstitute.org** and **hawati.hamid@krinstitute.org**

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Executive Summary

This working paper is part of studies within KRI's broader research on Gender and Care Work. It aims to provide a comprehensive overview of Malaysia's care landscape, focusing on the evolving needs for care, the current supply of care services and the gaps in care provision. The study examines care across different life stages, focusing on care for early and later years for children and the elderly, and lifelong support for persons with disabilities (PWDs). As Malaysia experiences demographic shifts, there is a pressing need to reassess the adequacy of care systems to meet the growing demand. The key findings and policy implications are summarised below:

Key findings

1. Increasing Care Needs Amid Demographic Shifts

Malaysia's population is ageing rapidly, and as fertility rates decline and family structures evolve, there is an escalating demand for care, particularly for the elderly and PWDs. This shift also increases the demand for childcare, as more families rely on external support due to changing gender roles and work patterns. Meanwhile, market supply of care services is not keeping up with demand and remains unevenly distributed. Childcare facilities are primarily concentrated in urban areas, while long-term care for the elderly and PWDs relies heavily on the private sector, leaving gaps particularly for low-income and rural populations. Additionally, the burden of care is uneven across multiple dimensions including gender, age groups and regions, and if left unaddressed, is likely to perpetuate inequality. These challenges underscore the need for a robust care infrastructure and targeted investment in underserved communities and regions.

2. Gaps in Accessible, Affordable and Quality Care

The high cost of formal care often leads families to rely on informal and/or unpaid care, a burden that disproportionately falls on women. The lack of affordable and quality care options, especially for long-term care, and the uneven distribution of care facilities limit accessibility for many, particularly in underserved regions. Additionally, both government and market-provided facilities face resource constraints, putting caregivers and care recipients at heightened risk of burnout, neglect and poor-quality care.

3. Fragmented Governance Limits Effective Care Delivery

Care oversight is concentrated under the Ministry of Women, Family and Community Development to oversee care delivery across all three categories of care recipients. This has led to care being stigmatised as primarily a women's and welfare issue, when in reality, it is a cross-cutting concern that affects areas such as workforce development, productivity and labour protection. Additionally, multiple agencies oversee different components of care based on their respective mandates, resulting in fragmented governance. While frameworks exist for regulating formal care services, significant gaps exist in coordinating across sectors, particularly in integrating informal care into the national policy agenda. This disjointed governance structure limits the effectiveness of care services, particularly in addressing the diverse needs of care recipients across different life stages.

Policy Implications

1. Promoting Growth of Care Market

In furthering the agenda of the care economy and creating an affordable, accessible and good quality ecosystem of care provision, the government plays a significant role in driving the growth of the sector. Increased investment in care can be made through a mix of public revenue injection, incentivising the private sector investment and leveraging government linked investment arms, which are uniquely positioned to drive growth and development within strategic sectors. Investment priorities should include incentives in the form of grant, subsidies and tax incentives to expand care infrastructures, workforce training, and research and development. These investments would enhance the capacity of care services, stimulate job creation and promote affordable, quality care.

2. Addressing Disparities by Expanding Government Support

The disparities in care provision, particularly in rural and underserved regions, highlight the urgent need for targeted interventions. Expanding public childcare facilities, long-term care centres and social support services will help reduce regional disparities and make care more accessible to vulnerable populations. Additionally, financial assistance, such as care subsidies or vouchers, can alleviate the financial burden on low-income families and ensure that more individuals have access to formal care services.

3. Strengthening the Care Framework

To effectively address the evolving care needs of Malaysia's population, it is essential to develop a cohesive and integrated care framework. This framework should prioritise collaboration between governmental agencies, NGOs, and private providers to enhance the availability and quality of care services. By ensuring that all stakeholders work together, Malaysia can create a more resilient and responsive care system that meets the diverse needs of its citizens.

Conclusion

To meet the growing care needs of Malaysia's population, it is essential that the further development of the care system emphasises an inclusive and equitable approach for all. Strategic investments in care infrastructure, financial support mechanisms and enhanced governance will ensure that the care sector can accommodate the rising demand and contribute to better social and economic outcomes for all citizens.

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1. Introduction

Care sustains the well-being of society and enables individuals to thrive. Care encompasses the act of looking after oneself or others and is essential for the well-being and functionality of every member of society. Care manifests in various forms, including tasks related to daily living maintenance such as cleaning and cooking, as well as relational caregiving, such as nurturing children and attending to those requiring assisted living. Throughout life, everyone requires care, with specific needs arising at different stages when we are unable to care for ourselves. At times, we may find ourselves either receiving care, providing care, or doing both simultaneously.

Malaysia has demonstrated an increasing recognition of the role of care in meeting the needs of individuals, families, communities and the economy[1]. With rapid urbanisation altering living arrangements, evolving gender roles, changing family structures and a demographic shift towards an ageing population, there is a pressing need to view care beyond traditional familial responsibilities. Investing in and expanding care services is crucial for addressing intersectional dimensions of poverty, gender inequality and social mobility. In many societies, individuals who face poverty or gender-based discrimination often encounter greater barriers to accessing quality care. By providing comprehensive care services, these disparities can be mitigated, ensuring that vulnerable populations receive the support they need. Moreover, as the population ages and social and physical mobility becomes a key concern, robust care systems are essential in reducing the impact of these factors on individuals' quality of life and opportunities for advancement.

The care sector holds significant potential as a growth area that can drive job creation and promote economic development and sustainability (see Box 1.1 for the economic potential of the care sector). Expanding and formalising care services not only creates new employment opportunities but also addresses issues related to informality and the decent work deficit. By investing in care infrastructure, societies can foster more stable and equitable employment conditions, enhance worker protections, and contribute to overall economic development beyond the care sector.

Furthermore, as societies face impending risks such as ageing populations and climate change, the importance of care becomes even more pronounced. The ageing demographic presents challenges related to increased demand for long-term care services, while climate-related issues can exacerbate vulnerabilities among those who are already in need of care. An example of this impact is the rise in climate-related disease outbreaks, leading to an increase in care recipients and shrinking of caregivers, with rural and marginalised communities bearing the brunt of these effects[2]. Effective care systems can help mitigate these risks by providing essential support and resilience to affected individuals, ensuring that they are better equipped to cope with changing conditions and unforeseen challenges.

[1] GOM (2021)
[2] Oxfam (2022)

Despite the recognised importance of care in addressing socioeconomic inequalities, promoting economic growth and mitigating risks associated with ageing and environmental changes, there remains a significant gap in cohesive and robust national strategies for care in Malaysia. As such, research on the care system in Malaysia is pertinent to identify changing needs, enabling the development of responsive care services that address specific needs at various life stages.

1.1. Objective of the study

This working paper is part of studies within KRI's broader research on Gender and Care Work. It aims to understand the landscape of care across different life cycles, focusing on children, the elderly and persons with disabilities (PWDs). It highlights the evolving needs for care and examines current provisions and challenges in Malaysia's care system amid demographic shifts facing the nation. The paper briefly explores care governance and further identifies gaps in the provision of care in terms of accessibility, affordability and quality.

The analyses in this paper are primarily based on data from:

- Department of Statistics Malaysia (DOSM)
- The Malaysian Department of Social Welfare (*Jabatan Kebajikan* Malaysia, JKM) under the Ministry of Women, Family and Community Development (*Kementerian Pembangunan Wanita dan Kebajikan Masyarakat*, KPWKM)
- Ministry of Education (MOE)

These data are further supplemented by insights from various studies from the literature.

1.2. Organisation of the paper

This paper is organised as follows:

- **Section 1: Introduction** sets out the context, key definitions and scope of the study.

- **Section 2: Evolution of Care Needs** examines how care needs have transformed in response to demographic shifts and its impact on dependency ratios and evolving family dynamics.

- **Section 3: Care Governance** describes the regulation and provision of services for childcare, long-term care and social support.

- **Section 4: Care Supply** dives deeper into the provision of care services, assessing the availability of childcare, long-term care, and social support services.

- **Section 5: Gaps in Care Provision** assesses current gaps in care provision, including challenges related to affordability, accessibility, and quality.

- **Section 5: Conclusion** concludes the study by summarising the key findings and proposing future considerations.

1.3. Key definitions and scope of work

This section defines key terms in relation to the care landscape which will be used throughout this paper. Although there is no consensus on what the care economy and its components comprise of, with different institutions and stakeholders having varying interpretations, the following definitions have been selected based on its applicability to the Malaysian context.

Care system refers to an overarching end goal of an innovative care delivery model. It envisions a comprehensive system that integrates legal and policy frameworks, services, financing, social and physical infrastructures, programmes, standards and training, governance and administration as well as social norms. A care system is also aimed to create a fairer ecosystem of care, through establishing co-responsibility between genders, households, the state, market families and communities[3].

Care economy refers to the sum of all forms of paid and unpaid care work. This includes all segments of society contributing towards the architecture of care provision, from state, market, families and community[4].

Care actors described in this paper can include both provider and regulator entities. For providers, this can consist of the state, market, families, and community (including non-government organisations or NGOs). Regulators include government agencies such as JKM and local authorities that oversee the registration, licensing and monitoring of care centres and implementation of care programmes.

Care work involves the provision of physical, emotional, psychological and developmental support to a care recipient and can be directly or indirectly provided. **Direct care** includes personal and relational care giving activities such as helping an elderly or disabled individual with daily tasks like bathing and grooming; supervising, feeding and nurturing children at day-care centres or in homes; and providing emotional support by listening and engaging in social interaction to enhance mental well-being. In contrast, **indirect care** refers to tasks that support caregiving but may not involve personal and face-to-face interactions such as cleaning or cooking performed by hired domestic workers or cooks in care centres[5].

Caregivers refers to individuals who perform care work, both paid and unpaid and in formal and informal settings. In this study, we refer to caregivers who provide care for pay as **paid care workers**, while those carrying out the work without explicit monetary compensation as **unpaid caregivers**.

- In **formal** settings, caregivers are **paid care workers** who are trained to provide care services in a professional capacity and/or employed in a registered care centre. Examples include nurses, early childhood educators and social workers.

- In **informal** settings, caregivers consist of unregistered individuals who provide **paid** care services without formal training, as well as family members and volunteers who are typically motivated by personal relationships and emotional connections rather than financial compensation. These **unpaid** caregivers often provide support to family members but may also care for individuals outside their household or within their community[6].

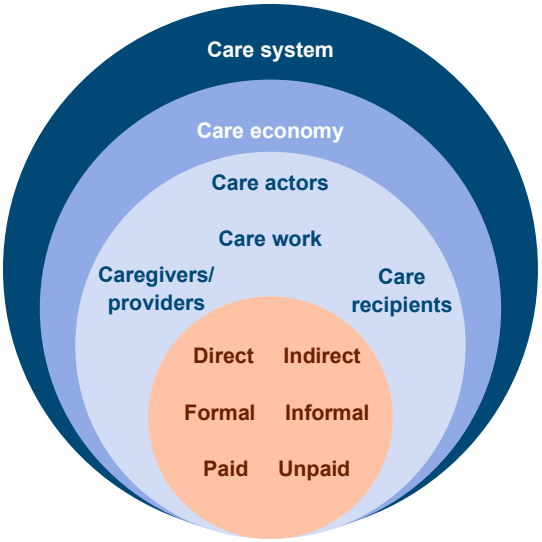
[3] United Nations (UN) (2024a)
[4] ILO (2024)
[5] ILO (2018); Hafiz Hafizi Suhaimi and Hawati Abdul Hamid (2024)
[6] ILO (2018)

Further discussion on caregivers who perform both paid and unpaid care work can be found in KRI's working paper titled "Recognising and Rewarding Care Workers"[7].

An overview of the key concepts discussed above and how they interact with one another are shown in Figure 1.1. **This paper focuses on direct, paid care work** which is defined as work performed for pay or profit, whether in a formal or informal setting.

Additionally, emphasis is given on **care provided by the state, market and community**. The primary care recipients addressed in this paper are **children, the elderly and PWDs,** as these groups represent populations with significant and often continuous physical and emotional care need.

Figure 1.1 Key concepts in the care landscape



Source: KRI illustration

The definitions for these recipients in Malaysia are as follows:

- **Children** refers to those below the age of 15. According to WHO, this population segment is considered as dependents and non-economically productive[8].
- **Elderly** refers to a person aged 65 and above, according to DOSM. However, JKM follows the World Assembly on Ageing 1982 in Vienna which defines an elderly person as someone who is above the age of 60[9]. For this paper, we will follow the definition set out by DOSM.
- **PWD** refers to those who have long-term impairments, whether physical, mental, intellectual or sensory, which may contribute to an inability to fully and effectively participate in society[10].

[7] Hafiz Hafizi Suhaimi and Hawati Abdul Hamid (2024)
[8] GOM (2019); WHO (n.d.)
[9] JKM (2024a)
[10] GOM (2008)

Box 1.1: Potential of economic and social benefits of Malaysia's Care Sector

The care sector in Malaysia presents substantial potential for economic and social gains, offering a path to drive job creation, support gender equality and foster sustainable development. Strategic investments in this sector can expand workforce participation, particularly for women, and enhance social services for vulnerable groups.

A 2024 UNDP report identifies Malaysia's care economy as a critical area for development and highlights the substantial economic and social benefits of investing in this sector[11]. By classifying care-related industries using both broad[12] and narrow[13] definitions and estimating their impact through input-output analysis, the report reveals that investment in the care economy can yield high economic returns, particularly by expanding employment opportunities for women and supporting underserved groups like the elderly and PWDs.

The report indicates several key results for Malaysia's care economy based on different investment scenarios:

- **Government Spending Impact**: A 5.0% increase in government investment has the most significant output impact, with a 3.9% boost in final demand output. This government-driven model, including investment in sectors like healthcare and education, is shown to have a robust impact on Gross Domestic Product (GDP) (5.8% increase) and employee compensation (11.4% increase). Employment impact is similarly strong, with around 1.3 million new jobs created, reflecting the labour-intensive nature of care services and the high demand for skilled care professionals.
- **Private Sector Investment**: A 15.0% increase in private sector investment in care-related services results in a 0.6% rise in final demand. This outcome is consistent across both broad and narrow definitions of the care economy, suggesting that private investment is somewhat independent of government interventions in areas like education and healthcare. The private sector expansion predominantly benefits areas like social work, technology-related care services and retail.
- **Household Consumption Impact**: A 10.0% increase in household consumption in care services shows a more than twofold effect when broad care economy definitions are used (2.7% output increase) compared to narrower definitions (1.2%). This reflects higher household expenditure on services within schools and hospitals. Additionally, the scenarios show a noticeable uplift in GDP and tax revenue from increased consumer spending, underscoring the demand for care services among households.

[11] UNDP (2024)

[12] Includes Education (118) and Health (119) sectors, consistent with the broad ILO list of Care sector,

[13] Does not include Education (118) and Health (119) sectors, to allow a focus on intervention outside school or hospital-based care

- **Employment and Wage Improvements**: Expansion in the care economy, especially from government and private sector investments, is projected to boost employment significantly, with women likely occupying most new roles. Wage increases and enhanced working conditions are also highlighted as essential, given existing recruitment and retention issues in the sector. This effect is particularly pronounced in high-demand areas like early childhood education and elder care, where skill-specific roles drive up compensation requirements.

Meanwhile, a complementary study by ISIS Malaysia underscores the economic values of unpaid care work[14]. Using standard methods to approximate the market value of domestic work, the report asserts that if unpaid care work produced in Malaysian households were included in national GDP figures, it would contribute approximately RM379 billion in economic value. In fact, unpaid care and domestic work would account for about a fifth of the service sector, positioning it alongside other market services. As a standalone services subsector, it would rank as the second largest after manufacturing if factored into GDP.

These figures highlight the substantial potential in valuing care work, especially for Malaysians who wish to work but are constrained by family and care responsibilities. In 2022, over 3.1 million people were excluded from the labour force due to family obligations and housework, with an additional 21,100 engaged in part-time work for the same reasons. Combined, this represents about 3.2 million Malaysians who had to reduce their work hours or withdraw from the workforce due to domestic obligations—98.0% of whom are women.

It is estimated that fully enabling these 3.2 million workers to participate in paid employment or transition from part-time to full-time roles could generate around RM77.2 billion in economic value annually, adding about 4.9 percentage points to GDP in 2022 alone. This change would likely increase women's labour force participation from 56.0% in 2022 to about 83.0%, effectively closing the workforce participation gap between women and men and surpassing Malaysia's current target of 60.0%.

Together, these projections highlight the significant economic and social benefits that can arise from reducing the constraints of care and domestic responsibilities. By investing strategically in Malaysia's care economy, many individuals would gain greater freedom and choice to engage in the market economy, driving gains in employment, productivity, and social equity.

[14] ISIS (2024)

2. Evolution of Care Demand

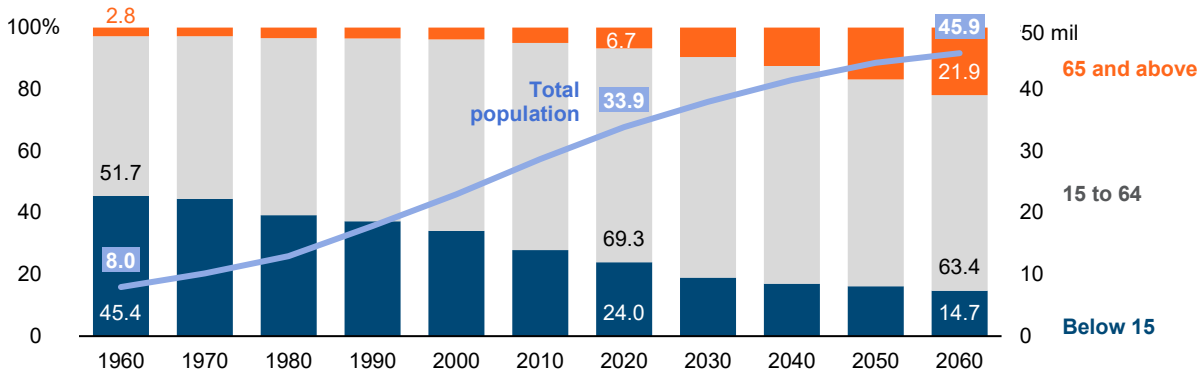
The care needs of the future are heavily influenced by shifts in demographic structure, ongoing epidemiological transitions and current economic changes. On a global scale, the population is projected to become increasingly urban and increasingly aged[15]. The global average fertility rate has halved as compared to the 1960s and has been coupled with systematic declines in elderly mortality rates, affecting the balance of those who need care and those who can provide it[16].

Malaysia has also undergone rapid demographic changes over the years, as will be discussed further in this section. Beginning in 2010, the nation experienced a burst in the size of the ageing population. According to the World Bank, the pace of ageing in Malaysia matches that of Japan, a country with the highest proportion of elderly people in the world[17]. Although it may be a testament to the performance of Malaysia's healthcare system, driving increases in life expectancy, it should be noted that another major contributor to the ageing phenomenon is the nation's rapid decline in fertility rate.

2.1. Overall population structure

Analysing Malaysia's population structure from 1960 to 2060 (Figure 2.1), there have been significant changes across the three main age groups of children, working age and the elderly.

Figure 2.1: Malaysia's population structure, 1960 – 2060



Source: UN (2024b)

In the 1960s, those of working age made up the largest proportion of the population (51.7%) with the second largest group comprising of children (45.4%). As the decades progressed, particularly between 1970 to 1990, the share of children gradually declined and those of working age increased. During this period, the elderly population remained small, although beginning to show signs of growth.

[15] UN (n.d.)
[16] Dukhovnov, Ryan, and Zagheni (2022)
[17] World Bank (2020)

Entering the 2000s, the decline in the children's population share became more pronounced, dropping to 24.0% in 2020. On the other hand, the working age population peaked in 2020 to reach 69.3% and the elderly population began growing more noticeably, indicating the onset of Malaysia's shift towards an ageing nation.

Looking ahead, projections for 2040 and 2060 show a dramatic increase in the elderly population. A 15.2 percentage point increase is expected between 2020 and 2060 for those 65 years old and above, reaching 21.9% in 2060. Meanwhile, the working age and child population is expected to decline to 63.4% and 14.7% respectively. These trends of large elderly citizen population and shrinking younger population point towards the challenges Malaysia will face in the future, particularly surrounding social protection, healthcare and income security for the elderly[18].

2.2. Malaysia's dependency ratio

Typically, the care burden of a country is co-determined through the total care need of a population and the pool of potential caregivers[19]. This feeds into a measure known as the dependency ratio (DR), which effectively represents economic dependency. The DR is calculated as below[20]:

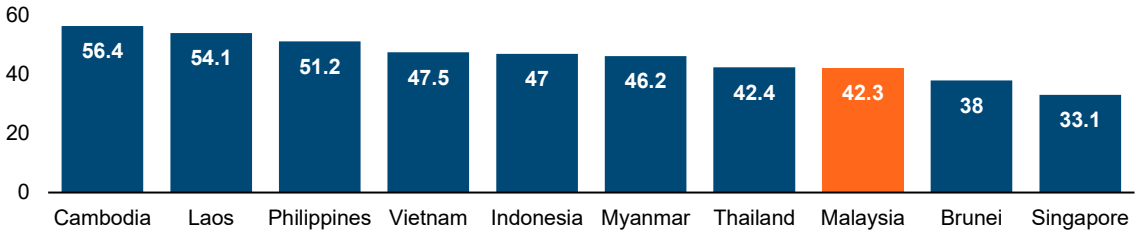
$$\mathbf{DR} = \frac{\text{Sum of total number of children aged } 0 - 14 \text{ and total number of adults aged 65 and above}}{\text{Total number of adults aged } 15 - 64 \text{ years}}$$

The assumption applied to the DR calculation is that both children and the elderly are non-productive economically and are thus dependent on adults between the ages of 15 and 64. Some research has argued against the accuracy of the DR since not all working-age adults are employed and not all those in the children or elderly age groups are out of the labour force. However, this is still a widely used measure of care burden and preliminary indicator of potential social support needs of a nation.

Malaysia has a DR of 42.3 as at 2023, lower than the upper middle-income average of 46.5[21], indicating that we still have a large proportion of economically productive individuals in the population. As compared to other peer nations in Southeast Asia, Figure 2.2 shows that Malaysia's DR is also still relatively low. As described by the World Bank, Malaysia is currently in a "demographic sweet spot" with the DR at an all-time low since 1970 due to the decline in young-age DR, i.e. less children relying on the working age population[22]. This is expected to change as the demographic projections described in Section 2.1 come into effect.

[18] UNDP (2024)
[19] King et al. (2021)
[20] WHO (n.d.)
[21] UN (2024b)
[22] World Bank (2020)

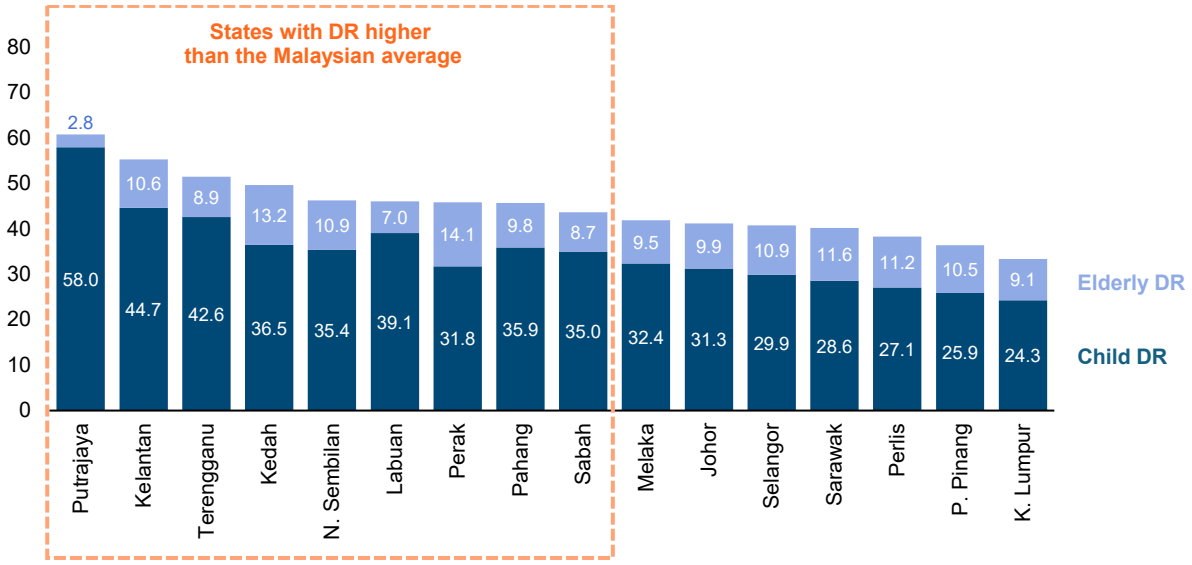
Figure 2.2: Dependency ratio in Southeast Asian countries, 2023



Source: UN (2023)

It should also be highlighted that the care burden is not equal across all states as illustrated in Figure 2.3. In 2023, nine of the states in Malaysia recorded a DR that was higher than the Malaysian national average. For all states, the care burden is mainly driven by the population of children.

Figure 2.3: Dependency ratio by state and age group, 2023



Source: DOSM (2023)

Putrajaya recorded the highest DR at 60.9 with a child DR of 58.0. Worryingly, states that have been reported to have a large number of households in absolute poverty also tend to have a higher-than-average DR. For example, Kelantan, Kedah and Perak have DRs of 55.4, 49.6 and 46.0 respectively. These three states have been found to have districts with a prevalence of poor households that were significantly above the national average[23].

A previous KRI study has applied a modified version of the care dependency ratio, incorporating labour market dynamics, to better reflect the variation in care needs across the entire population. Their findings illustrated that Malaysia's care burden increased between 2010 to 2018, particularly as more of those aged 20 – 64 entered the workforce, leaving the majority of care to those outside the workforce[24].

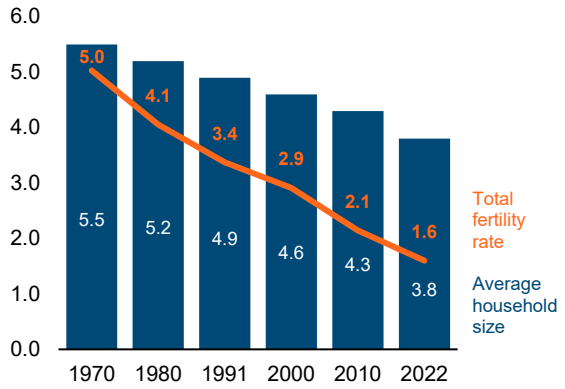
[23] KRI (2024)
[24] KRI (2019)

2.3. Evolving family structures and household composition

Over the decades, the structure of families and composition of households in Malaysia have changed. Data from 1970 to 2022 reveal a steady decline in both average household size and the total fertility rate (Figure 2.4a).

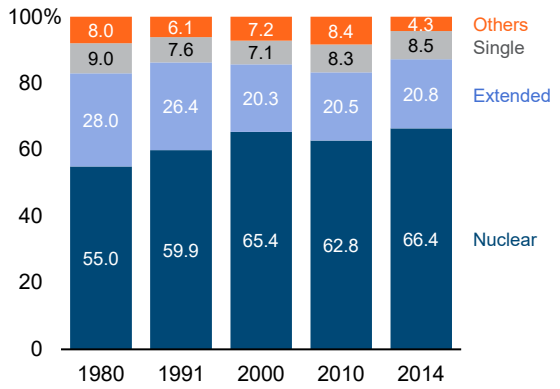
Figure 2.4: Family structure

a) Average household size and total fertility rate



Source: DOSM (Various years), UN (2022)

b) Household composition



Source: DOSM (Various years), UN (2022)

In 1970, families typically had an average of 5.5 members and a Malaysian woman would have an average of five children during her lifetime (Figure 2.4a). As the years progressed, both household size gradually decreased, falling to 4.6 in 2000 and further down to 3.8 in 2022. Fertility rates experienced an even more pronounced drop to 1.6 in 2022. Taken together, these trends indicate a shift towards smaller families, perhaps driven by individual decisions to get married later in life, avoid the rising cost of having children and prioritise caring for ailing parents[25].

At the same time, there was also an evolution in Malaysia's household composition, although to a smaller extent (Figure 2.4b). In 1980, the nuclear family model, consisting of core members of the family i.e. parents and children, represented 55.0% of all households in the country. Households made up of extended families, where at least one elderly parent lives with their adult child, accounted for 28.0% of the total in the same year.

Moving into the 2000s, the number of extended family households shrunk further, declining to make up 20.8% of total households in 2014. The proportion of nuclear families in turn steadily increased and reached 66.4% in 2014. Single households and other forms of living arrangements[26] have fluctuated slightly across the period of 1980 to 2014, contributing to less than 20.0% of total households.

[25] Dukhovnov, Ryan, and Zagheni (2022); The Sun (2024)

[26] Other forms of living arrangements would include living with an unrelated member or other related members

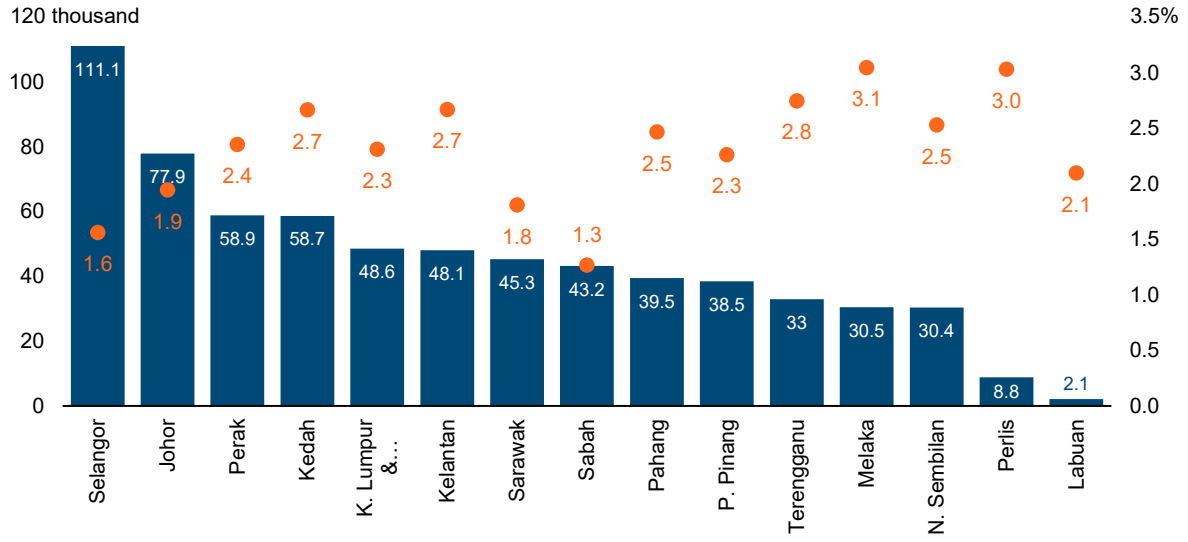
The overarching trend is clear. Family structures are moving towards being smaller, more independent units. The majority of households in Malaysia are nuclear with small numbers of children. This pattern could be contributed to the increased urbanisation seen in the country accompanied with higher living costs. In 2022, 80.0% of households in Malaysia were urban[27]. Additionally, living with dependents, both young and old, is costly especially in areas where economic opportunity is more concentrated.

2.4. Taking into account PWD

The burden of care cannot be accurately assessed without considering the population of PWDs. As of 2023, approximately 1.3 billion people globally experience a significant disability, and this number is expected to grow over time largely contributed to by the rise in non-communicable diseases and an increasing lifespan[28].

In Malaysia, it was reported that there were 675,548 registered PWDs in 2022, with the distribution of PWDs across states shown in Figure 2.5. Of this total number, the highest concentration of PWDs were found in Selangor with over 110,000 PWDs and the lowest concentration was seen in Labuan with only a little over 2,000 PWDs.

Figure 2.5: Number of registered PWDs and share to population by state, 2022



Source: DOSM (2022)

However, when factoring in the share of PWDs to the total population, Perlis, Kelantan and Kedah had the highest burden, with PWDs making up 3.0%, 2.7% and 2.7% respectively. This is a worrying fact considering these states have among the lowest average incomes in the country[29].

Additionally, it should be noted that in Malaysia the main source of information on the PWD population is through the registration of PWDs under JKM. This registration is on a voluntary basis and provides the benefit of inclusion into government services or assistance programmes

[27] KRI (2024)
[28] WHO (2023)
[29] KRI (2024); World Bank (2022)

specific to PWD[30]. However, since it is voluntary, it is likely that the true number of PWDs in the country is underrepresented in the JKM database. A lack of awareness and difficulties verifying disabilities especially in rural areas has been cited as a barrier to PWD registration in Sarawak[31]. This potentially applies to other states as well.

In Malaysia, there are seven categories of PWDs. A summary of the categories and their definitions are provided in Table 2.1. In 2022, the majority of PWDs had a physical disability (36.3%) or learning disability (35.1%). The smallest proportion of PWDs were those with speech disabilities, making up only 0.5% of the PWD population.

Table 2.1: Categories of PWDs in Malaysia

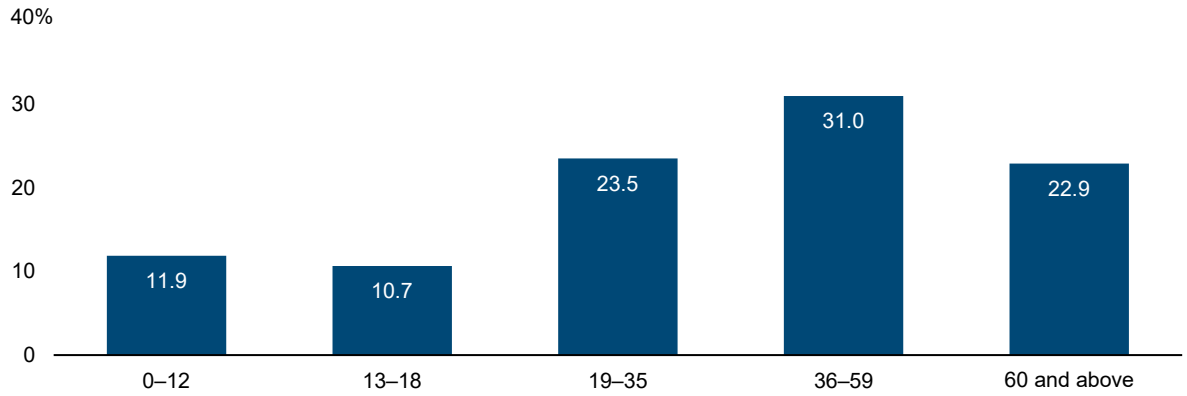
Type of Disability	Definition	Share of total PWD population in 2022 (%)
Hearing	• Individuals who are unable to hear clearly without hearing aids or unable to hear even with hearing aids	6.5%
Learning	• Individuals whose intelligence does not match their biological age • This includes individuals with conditions such as Down syndrome, autism, dyslexia and Attention-deficit/hyperactive disorder (ADHD).	35.1%
Mental	• Individuals with severe or chronic mental disorders that have undergone treatment or have been given a diagnosis by a psychiatrist for at least two years • These individuals would be unable to function either partially or fully for himself or for the community even after treatment. This includes individuals with schizophrenia and mood disorders	8.2%
Physical	• Individuals suffering from an inability of the body to function normally whether by injury or disease • This includes individuals who experience stunting, crippled limbs, paralysis, spina bifida and cerebral palsy • This does not include individuals whose impairment does not affect their normal bodily functions such as handicapped one finger or has more than ten fingers.	36.3%
Speech	• Individuals who are able to hear but are unable to speak, resulting in disrupted communication and an inability to be understood by those around them	0.5%
Visual	• Individuals who have a visual impairment or low vision in either one eye or both eyes, even with visual aids such as spectacles and contact lenses • This includes individuals who are blind or partially sighted	8.8%
Others	• Individuals with more than one type of disability and cannot be classified under any of the other existing categories	4.6%

Source: Public Services Commission of Malaysia (n.d.), JKM (2022)

[30] Siti Marshita Mahyut (2017)
[31] Malay Mail (2023)

When broken down by age group (Figure 2.6), it can be seen that a large proportion of PWDs come from the 60 and above age group, followed by those in the 36 – 59 age group. This implies that there is a double burden of ageing and disability where they are unable to contribute to the economy and also require a degree of care for their daily lives. Additionally, the prevalence of disability those in the working age group highlights a proportion of adults that may or may not be able to be fully economically productive and may even be dependents, skewing the dependency ratio further.

Figure 2.6: Proportion of registered PWDs by age group, 2022[32]



Source: DOSM (2022)

[32] Granular data for PWD registration by age was not available

3. Care Governance

Care governance is crucial in shaping the delivery and quality of care services in Malaysia. This section briefly covers the entities involved in governance of care services across different sectors, touching on the types of provisions available and regulatory frameworks that apply. These insights will provide the reader with background information on Malaysian care provision which is crucial for Section 4 and 5.

3.1. Childcare

Generally, formal care provision for children is referred to using the term "early childhood care and education", or ECCE. This usually covers the period from birth to pre-primary school age, generally considered to be under six or seven years old. According to UNESCO, this period is a critical time for a child as it will dictate the development of their health, nutrition, learning success and social-emotional wellbeing[33].

Compared to children of school-going age whose needs focuses on education; younger children require a greater emphasis on care giving. Particularly for those under three years of age, there is a need for responsive caregiving. This includes "observing and responding to children's movements, sounds and gestures and verbal requests". There is a very high dependence on caregivers to meet the needs of children and these needs vary across a wide spectrum that does not only include nutrition but also cognitive stimulation, emotional regulation and soothing[34].

In Malaysia, ECCE is typically divided into two groups according to age and the type of ECCE centres that they attend[35]. The first group includes children aged 0 – 4 whereas the second group consists of children aged 5 and 6.

Children aged 0 – 4 in Malaysia who are enrolled into ECCE programmes will attend Taman Asuhan Kanak-Kanak (TASKAs) or nurseries. These TASKAs fall under the governance of KPWKM, [36]. The Childcare Centre Act, enacted in 1984, outlines specific provisions related to TASKAs, including their registration and monitoring[37].

Registered TASKAs include community-based, home-based, institution-based and workplace-based[38], all of which provide paid care. As of 2023, 70.6% of providers for this category of ECCE were private, communities or NGOs, while the remaining TASKAs were government-operated, typically offered at a much lower price. For example, one of the governments TASKAs, TASKA KEMAS only charges a maximum monthly of RM100, with lower fees for those of lower income (more details provided in Section 4). A summary of the differences between TASKAs are provided in Table 3.1.

[33] UNESCO (2024)
[34] WHO, UNICEF, and World Bank (2018)
[35] Kong (2021)
[36] Kong (2021); Chiam (2008)
[37] JKM (2020)
[38] MyGOV (n.d.)

Table 3.1: Differences between TASKA categories

Type of TASKA	Number of children	Criteria
Community-based	10 or more	• Receives assistance from federal and state governments • Set up as a community initiative for the benefit of low-income families
Home-based	Between 4 – 9	• Based in a residential space
Institution-based	10 or more	• Set up under private or NGO initiative
Workplace-based	10 or more	• Set up as an employer initiative for employee welfare

Source: MyGov (n.d.)

For children between the age of 5 – 6, kindergartens and pre-schools are the main providers of formal care[39]. These facilities equip children with formal education to prepare for primary school and are governed mainly by MOE. The relevant governance framework for kindergartens and pre-schools is the Education Act 1996 which includes pre-school education as part of the formal education system.

Besides MOE, other agencies such as the Majlis Agama Islam Wilayah Persekutuan (MAIWP) and Jabatan Agama Islam Selangor (JAIS) as well as private entities are also providers of care for this age category[40]. Unlike the younger age group, the provision of ECCE for 5 – 6 year olds is mostly by the public sector (68.1%).

However, a 2024 landscape analysis of the care economy in Malaysia conducted by UNDP reported that for many families, the burden of childcare still fell on informal arrangements. Faced with high costs of childcare services, many young children in Malaysia receive care from parents, grandparents or ad-hoc babysitters such as neighbours or older siblings[41]. Alternatively, parents may also opt for unregistered childcare centres or home-based carers which would typically offer more affordable prices. These types of informal care arrangements are not governed by any entity, with no assurance of quality nor safety.

These findings of a reliance on informal childcare have been echoed by a 2024 report by ISIS Malaysia, highlighting that informal caregiving, predominantly provided by women family members, often goes unpaid or underpaid driven by the high cost of formal services and societal norms of filial piety that discourage families from seeking professional help[42]. Further discussion on the supply and the gaps in meeting the demand can be found in Sections 4 and 5.

[39] UNDP (2024)
[40] MyGOV (n.d.)
[41] UNDP (2024); Sinar Daily (2024)
[42] ISIS (2024)

3.2. Long-Term Care

The growing population of elderly and PWDs in Malaysia highlights the need for long-term care (LTC). The goal of LTC is to support the wellbeing and daily functioning of those who have chronic illnesses, physical limitations or mental disabilities. Although not all of the elderly population may have a serious health condition, the nature of ageing results in a degree of mobility and self-care limitation[43]. According to the World Health Organization (WHO),

> *"Long-term care encompasses activities undertaken by others to ensure that those with a significant ongoing loss of physical or mental capacity can maintain a level of ability to be and to do what they have reason to value; consistent with their basic rights, fundamental freedoms and human dignity*[44]*."*

In the context of this paper, LTC refers to care received while residing in a facility on a permanent basis or for more than six weeks[45]. The provision of LTC consists of assistance in two main areas: (1) activities of daily living (ADL) and (2) instrumental activities of daily living (IADL)[46]. ADLs are related to meeting the basic physical needs of the care recipient and includes tasks such as feeding, dressing and personal hygiene[47]. On the other hand, IADLs involve more complex thinking skills and relate to the care recipient's ability to live independently such as grocery shopping, tracking medication and managing transportation[48].

LTC in Malaysia is mainly governed by KPWKM, with an additional authority of the Ministry of Health (MOH) due to the medical needs of this population. For the elderly, the main acts that ensure the provision of care are the Destitute Persons Act 1977 (DPA) and the Care Centres Act 1993 (CCA)[49]. However, the DPA only applies to elderly who are homeless and impoverished and does not cover a large proportion of the population. The CCA on the other hand only governs registered LTC facilities. For PWD, the Persons with Disabilities Act 2008 outlines specific provisions for PWDs and establishes the National Council for Persons with Disabilities in Malaysia which makes legislative recommendations related to disability law[50].

LTC for the elderly could be provided through home-based care for extended periods of time such as through home nursing programmes, ADL support or domestic workers. It could also encompass more medically specific care through rehabilitation centres, nursing homes for neurodegenerative disease patients or hospice care for those nearing the end of life (see Box 3.1 for a brief discussion on medical needs). These types of facilities would require a team that is medically trained including doctors and nurses[51].

[43] Fredriksen-Goldsen and Bonifas (2013)
[44] WHO (2015)
[45] Lim, Noralfishah Sulaiman, and Baldry (2013)
[46] Fredriksen-Goldsen and Bonifas (2013)
[47] Edemekong et al. (2023)
[48] Fredriksen-Goldsen and Bonifas (2013); Edemekong et al. (2023)
[49] JKM (2024a)
[50] GOM (2008)
[51] UNDP (2024)

Box 3.1: Medical LTC needs of the elderly

Although this paper does not discuss medical LTC for elderly, we acknowledge that it is also a pressing need for Malaysia. These medical LTC facilities cater for health needs which are, as outlined by the United Kingdom's National Health Service (NHS), "related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional)"[52].

The process of ageing naturally involves the gradual accumulation of various forms of damage at a molecular and cellular level, resulting in a decline in normal function of the human body and significant increase in disease risk[53]. This decline and increased risk are not linear nor consistent in nature, influenced by the randomness of ageing mechanisms as well as the socioeconomic background of the individual[54]. Age-related diseases can impact many physiological processes in the human body such as brain, cardiovascular, musculoskeletal and immune system functions[55]. These diseases would require specific care to be provided, often to prevent progression or to alleviate the symptoms of more irreversible, degenerative conditions.

In Malaysia, there is an estimated prevalence of probable dementia[56] of 8.5%, about 260,000 elderly persons in 2022. This prevalence was higher than the global prevalence reported by WHO. Dementia is a chronic neurodegenerative disease that causes a loss of cognitive functions such as thinking, remembering and reasoning, which in turn prevents the ability to perform even basic ADLs. The prevalence of probably dementia was also higher amongst elderly with low income, living in rural areas and were single[57]. Those with dementia require progressively increasing levels of support, particularly during their final years, and have been found to utilise LTC facilities more often[58]. However, those with dementia may not necessarily require medical-specific LTC.

Instead, medical LTC may be required for those with diseases such as cancer where management of specific symptoms are required to ensure a decent quality of life. For example, pain management through medication administration or massage techniques and delirium management through drug therapy[59]. This would require elderly cancer patients, particularly those with limited mobility, to receive care from a residential medical LTC facility or via regular home visits by medical personnel (including physiotherapists and nurses). In 2022, it was reported that in the Malaysian population above the age of 65, there

[52] UK Department of Health and Social Care (2022)
[53] Guo et al. (2022); WHO (2015)
[54] WHO (2015)
[55] Guo et al. (2022)
[56] The NHMS 2018 utilised a commonly used screening tool to test the condition of elderly participants. Those who scored lower than 10 were categorised as having probable dementia, since these participants may not have an official diagnosis for dementia.
[57] MOH (2018)
[58] SM-Rahman et al. (2022)
[59] Castelo-Loureiro et al. (2023)

were 3,383 cases of colorectal cancer, 3,174 cases of lung cancer, 1,987 cases of prostate cancer and 1,949 cases of breast cancer[60]. The burden of medical LTC needs is also not only limited to cancer but also applies to other diseases including diabetes and cardiovascular diseases.

Ultimately, Malaysia needs to consider the needs of elderly persons with varying functional abilities and health statuses, providing a wide range of services that promote decent quality of life across all categories.

This paper will focus on residential elderly facilities as a form of LTC for elderly without major and specialised medical needs. Residential elderly facilities can include old folk's homes, retirement villages and educational or religious centres[61]. In Malaysia, the majority of residential elderly facilities are provided by the private sector for profit or by NGOs.

The government only provides welfare institutional services for impoverished elderly as listed in Table 3.2, and these facilities are few in number. Since these are the only government provisions, this paper will explore these facilities despite the treatment aspect they offer.

Table 3.2: Types of government LTC facilities for the elderly in Malaysia

Type of facility	Criteria
Rumah Seri Kenangan	• Provides a place to stay and medical treatment for elderly Malaysian citizens with no close relatives and no income, but are able to be independent • Promotes social networking between elderly residents and active ageing[62] through activities carried out under the institution
Rumah Ehsan	• Provides care, treatment and shelter for the sick, homeless and heirless Malaysian elderly who are unable to be independent • Services include care, protection, physiotherapy, religious guidance, recreation, job recovery, medical treatment

Source: JKM (n.d.)

For PWD, LTC could include long-term treatment at health clinics or institutional care. The latter is the focus for this paper and, similar to LTC for the elderly, the main providers are private sector and NGOs. The government focuses less on LTC provision for PWD and instead invests more resources on social support, as will be discussed in the following subsection.

[60] WHO (2022)

[61] UNDP (2024)

[62] According to WHO, active ageing is a concept which provides a focus on enhancing the quality of life of the elderly by supporting their physical, social and mental wellbeing, alongside their participation in society (WHO, 2002).

The main LTC facility provided by the government of Malaysia for PWDs is Taman Sinar Harapan (TSH). This refers to institutes that provide care, shelter, rehabilitation and training for PWDs with learning disorders as well as providing care and shelter for those with severe disabilities. These TSHs also doubles as a place of shelter for children with learning disabilities[63].

Across the globe, the majority of elderly people receive care services at home and rely on informal care provisions[64]. Since Malaysia has yet to establish an LTC insurance, as seen in Singapore[65], or specific social security benefits, many of its older population also rely on informal LTC. It is difficult to determine what proportion of the PWD population receive formal or informal LTC, since this would potentially differ across the lifespan. For example, PWD of school-going age may not be admitted to an LTC institution but instead would be attending special schools or school programmes.

3.3. Social Support[66]

Another aspect of care provision can be seen as social support, referring to care that is provided on a short-term or daily basis to encourage living in place for both PWD and the elderly. In a survey published in 2019 looking at a population of over 1,000 adults aged 50 – 59 in Malaysia, it was found that 84.0% wished to grow old in their own homes[67]. Corroborating this high preference for ageing in place, according to the 2019 Malaysia Ageing and Retirement Survey, 75.0% of Malaysians aged 40 and above were not prepared to live in LTC facilities and 46.0% were not prepared to live alone[68].

In order to ensure that both the elderly and PWDs can live independently, safely and comfortably within their own home environment, it is important that we establish strong social support systems within the community. By strengthening the social connection between those who require care and the community around them, both mental health and overall health of those considered to be disadvantaged can be positively impacted, thus improving their quality of life[69]. Some studies have even shown that social support to meet the daily needs of the elderly led to reduced hospital readmissions and length of stay[70].

[63] JKM (2024b)
[64] UN, n.d.
[65] In Singapore, all citizens and permanent residents contribute to a compulsory national LTC insurance scheme known as CareShield Life. This scheme provides monthly financial support should the contributor develop a disability, particularly in old age, to cover costs of personal care and medical care.
[66] This paper will not focus on education of PWDs, instead focusing more on social support that is aimed at general development of those with disabilities
[67] Shamzaeffa Samsudin et al. (2019)
[68] SWRC (2021)
[69] Tengku Amatullah Madeehah T. Mohd et al. (2020); Nur Zahirah Balqis-Ali and Fun (2024a); Shen et al. (2022); Noorlailahusna Mohd Yusof and Suziana (2023)
[70] Nur Zahirah and Fun (2024)

Social care is envisioned to be the best of both worlds since it offers the advantages of being in a familiar environment, while also receiving professional care. This social support can be in the form of social activities and community events. Similar to LTC, KPWKM governs social support centres and the implementation of social support, delivered in collaboration with other government agencies and NGOs[71]. A summary of government social support initiatives for elderly and PWDs is provided in Table 3.3.

Table 3.3: Main government initiatives for social support of elderly and PWD in Malaysia

For elderly	For PWD
• **Pusat Aktiviti Warga Emas:** Community day-care centres • **Unit Penyayang Warga Emas:** Transportation services for health purposes • **Home Help Services:** Volunteer based services for at-home support	• **Independent Living Centre:** Services centre • **Community-Based Rehabilitation:** Training centre for integration into society • **Bengkel Daya: T**raining and employment centre • **Industrial Training and Rehabilitation Training Centre:** Vocational training and rehabilitation centre • **TASKA Orang Kurang Upaya:** Day-care for PWDs between the age of 0 – 4 • **Pusat Khidmat Setempat Orang Kurang Upaya:** One-stop-shop for services • **Home Help Services:** Volunteer-based services for at-home support

Source: JKM (2024)

One of the main initiatives for social support provision by the government is the Pusat Aktiviti Warga Emas (PAWE), a community centre dedicated to elderly persons. PAWEs provide daytime services for the elderly to carry out daily activities within the community. Among the activities hosted at PAWEs include religious events, educational sessions, healthcare assessments, therapy sessions and recreational activities such as dancing and singing. While the main target group is those above 60 years of age, the PAWEs are meant to indirectly impact others in the local community such as children, teenagers, PWDs and women through intergenerational and interactive programmes[72].

More mobile social support services for the elderly include Unit Penyayang Warga Emas (UPWE) and Home Help Services (HHS). UPWE provides transportation services to healthcare facilities for elderly people who live alone or cannot afford it. The goal of UPWE is to ease the burden of cost and accessibility for the elderly to obtain health services[73]. On the other hand, HHS is an outreach programme for assistance with ADLs and IADLs. These services are delivered through registered volunteers and will be carried out once a week for at least one hour per visit[74]. The extent of services through HHS is determined based on the needs of the individual person[75].

[71] Noraida Ibrahim, Zarina Mat Saad, and Fatimah Zailly Ahmad Ramly (2016)
[72] JKM (2024a)
[73] JKM (2024c)
[74] KPWKM (2020)
[75] Bernama (2023)

As illustrated earlier in Table 3.3, most of the social support programmes for PWD focus on training of PWDs and encouraging their integration into society, employment in particular. Programmes such as Community-Based Rehabilitation (*Program Pemulihan dalam Komuniti* or PDK) and the Industrial Training and Rehabilitation Training Centre (*Pusat Latihan Perindustrian dan Pemulihan* or PLPP) both provide vocational courses. PDK also has the added focus on self-development and management as well as creative skills.

Bengkel Daya takes the training a step further by also providing opportunities for employment within the facility for those between the age of 18 and 45. Areas for employment include in sewing, baking and laundry.

Alongside these initiatives, there are also services centres such as the Independent Living Centre (ILC) and the Pusat Khidmat Setempat (PKS). The ILC provides basic services to empower PWDs such as peer counselling and personal assistants for ADLs. Similarly, PKS provides services for PWDs ranging from support, health, rehabilitation and employment. The HHS programme described earlier is also available for PWDs. Additionally, the government also specifically provides day-cares for PWDs aged 0 – 4, for early interventions to promote better outcomes[76].

For social support, it appears that there is no dominant provider between government and non-government entities. Both play complementary and supplementary roles, although their scale is still small (as discussed in Section 4.3) and will need to be expanded in the future to accommodate the rising needs of the population.

[76] JKM (2024a)

4. Provision of Care Supply

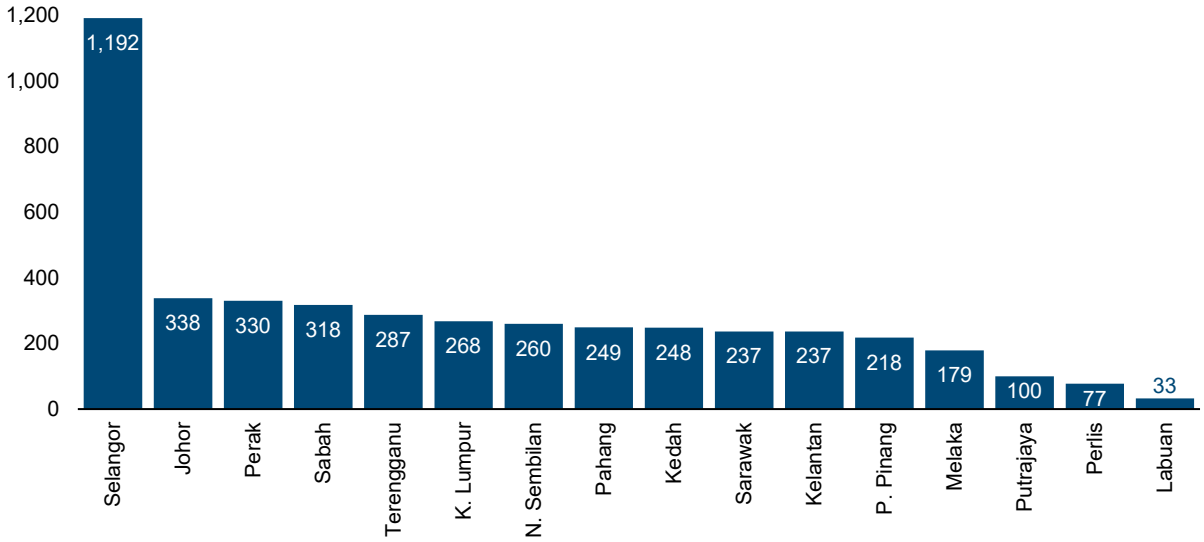
Care supply plays a critical role in ensuring that individuals across different life stages can access the care they need. This section looks into the availability of care services, focusing on the provision of childcare, long-term care, and social support services in Malaysia. It assesses the capacity of both government and non-government entities in delivering these services and evaluate how the current supply meets the growing and evolving care demands of the population. The analysis also considers the geographical disparities in care provision, providing insights into the adequacy of services and potential areas for expansion.

4.1. Childcare

The data used for this section is mainly from a dataset provided by the National Children Development Research Centre (NCDRC). NCDRC is a one-stop centre that offers data, services and collaborations with others on early childcare, education, and development in Malaysia. NCDRC also manages the National Child Data Centre (NCDC) which collects data on children aged 0 – 5, childcare centres and educators; monitors children's development; and provides information and reports on ECCE. However, it has a limitation where it captures only data that are provided directly by registered childcare centres and may not be comprehensive since it also depends on the cooperation of each centre to provide information. Besides that, it also compiles data only from 2015 onwards.

For children aged 0 – 4, there were 4,571 TASKAs in total as of 2022, provided for by both government and non-government entities. Figure 4.1 shows the breakdown of these TASKAs by state. Selangor had the highest number of TASKAs at 1,193, more than three times the number found in Johor, which had the second highest number of TASKAs at 343. Perlis had less than 100 TASKAs, although the child DR of Perlis was lower than most states thus there may not be much demand.

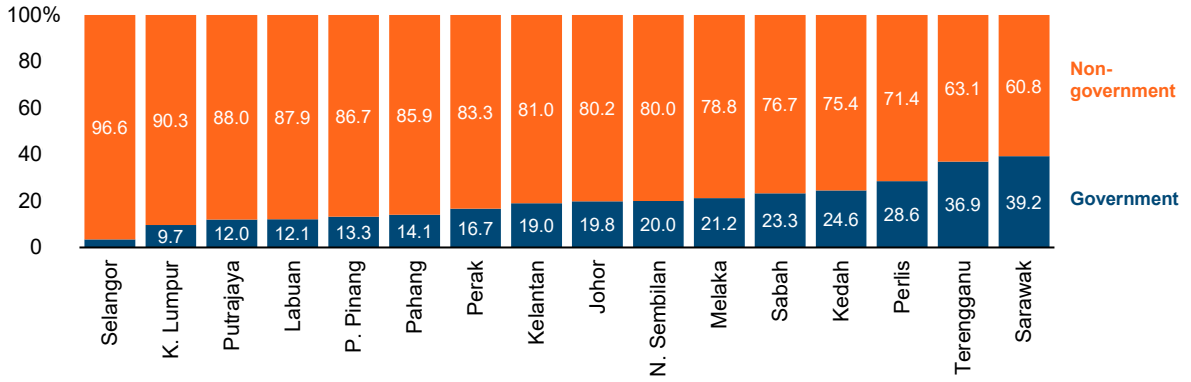
Figure 4.1: Number of TASKAs, by state, 2022



Source: NCDRC (2022)

Government provision of TASKAs makes up a small proportion of the total (760 government TASKAs in total) and the market is mostly non-government driven (Figure 4.2). In Selangor and Kuala Lumpur, government TASKAs make up less than 10% of the market share. This trend indicates that perhaps cost would become an issue for parents who would like to send their child for care under the age of four since they would have to compete for limited public providers and choose from private providers.

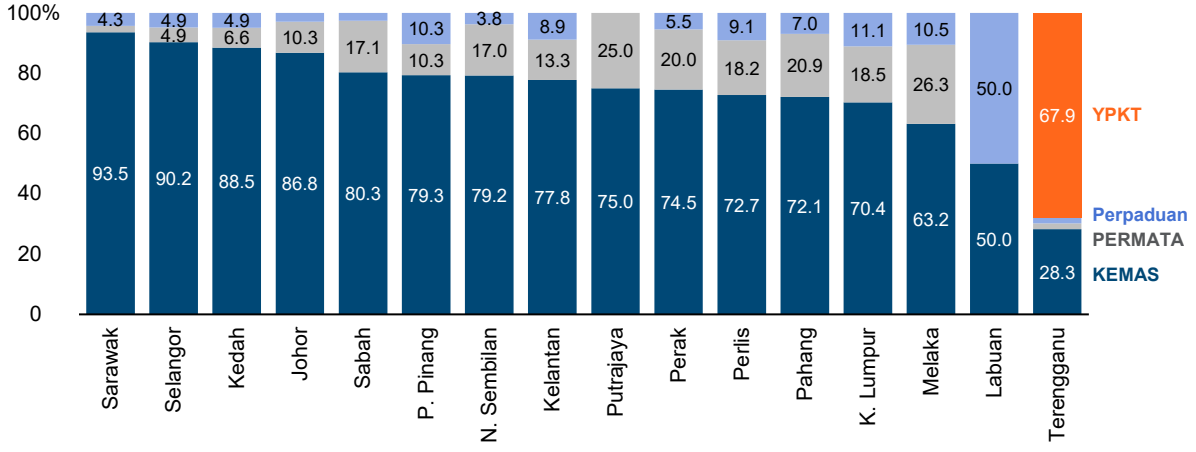
Figure 4.2: Government versus non-government TASKA, by state, 2022



Source: NCDRC (2022)

Although most of the non-government TASKAs were registered under JKM, there were also other government or government-related entities that directly provide TASKA services (Figure 4.3). The second largest provider of public TASKAs was KEMAS, with presence in all states. TASKAs under the state-specific initiative were found to a significant degree (25.0%) in Terengganu i.e. TASKA under the Family Development Foundation of Terengganu (or *Yayasan Pembangunan Keluarga Terengganu*, YPKT)[77]. A summary of the differences between government TASKAs is included in Box 4.1.

Figure 4.3: Breakdown of government TASKA, by state, 2022



Source: NCDRC (2022)

[77] It should be noted that other state-led TASKA initiatives also exist in other states, however the provision of TASKAs may be to a smaller degree or may instead be through cash assistance such as by Yayasan Warisan Anak Selangor. As mentioned earlier, this data provided by NCDRC is reliant on self-reporting by care centres and may be limited in capturing other state-led initiatives.

Box 4.1: Government agencies supplying childcare services

The majority of childcare facilities are under the direct purview of JKM, including registered private and NGO-run facilities. However, there are several government agencies that run TASKAs for 0 – 4 year olds, whether at state or federal level. The following provides a brief overview of these agencies.

- **TASKA KEMAS** are TASKAs that are run by the Department of Societal Advancement (*Jabatan Kemajuan Masyarakat*, KEMAS) under the Ministry of Rural and Regional Development. KEMAS has the mandate of eliminating illiteracy in the Malaysian population and thus has rolled out their own childcare facilities following curriculum provided by MOE and guidelines for childcare set out by JKM. These TASKAs cater to children aged 2 – 4 years old, although there are also pre-schools known as TABIKAs for 4 – 6 year olds.

- **TASKA Permata** is a part of the national PERMATA programme that aims to develop individual talents and potential from an early age through quality education. These TASKAs are directly under MOE and cater to children under the age of four.

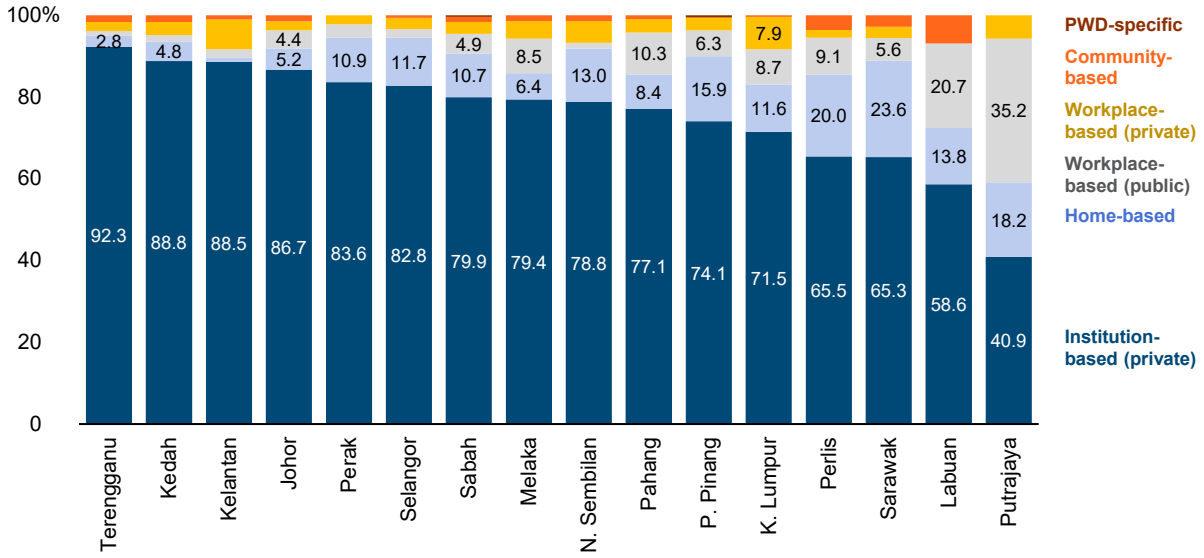
- **TASKA Perpaduan** refers to TASKAs that are set up under the National Unity and Integration Department (*Jabatan Perpaduan Negara dan Integrasi Nasional*, JPNIN). These TASKAs utilise the same curriculum as the TASKA Permata and emphasises inquisitiveness and creativity. These TASKAs cater to children under the age of four.

- **TASKA Permata Keluarga under YPKT** are TASKAs that are under the Family Development Foundation of Terengganu (*Yayasan Pembangunan Keluarga Terengganu*, YPKT). In Terengganu, YPKT provides care services and education for infants and children under the age of four to support families that are struggling to care for their children.

When examining the types of non-government TASKAs (Figure 4.4), it is apparent that the primary type is institution-based TASKAs provided by the private sector (private childcare centre). The other two main types are workplace-based TASKA in both public and public sector[78] and home-based TASKA, although they contribute to a much lesser extent.

[78] Public sector workplace-based TASKAs are made available to civil servants as a workplace initiative but may not necessarily be provided by the government or public sector

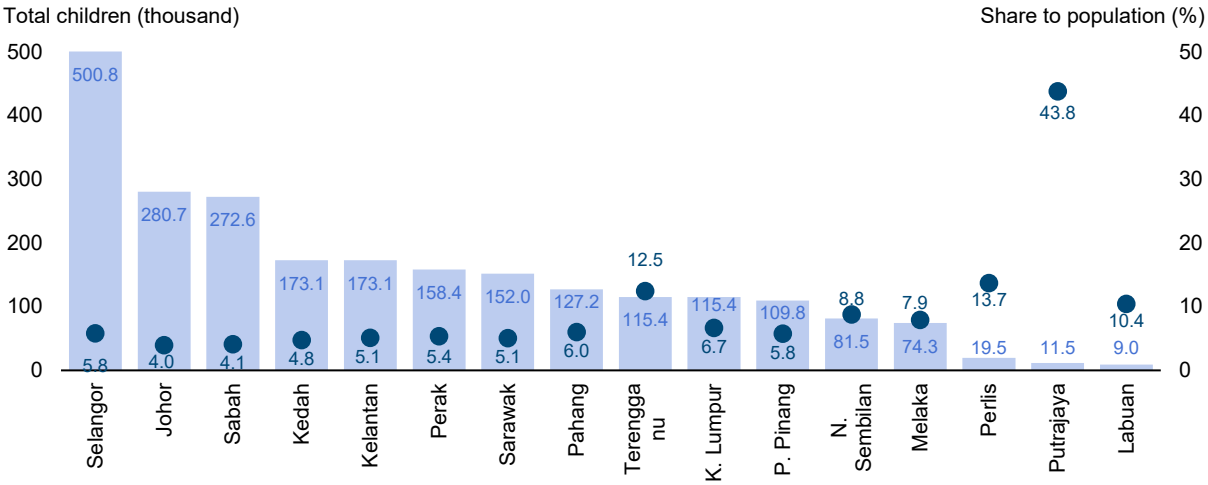
Figure 4.4: Breakdown of non-government TASKA, by state, 2022



Source: NCDRC (2022)

Figure 4.5 looks further into the enrolment of children into TASKAs in Malaysia. Notably, in most states, less than 10.0% of children aged 0 – 4 were enrolled in TASKAs. The exceptions to these were Perlis, Terengganu and Putrajaya.

Figure 4.5: Number of children enrolled in TASKA and share to population of 0 – 4 year olds, by state, 2022



Source: NCDRC (2022)

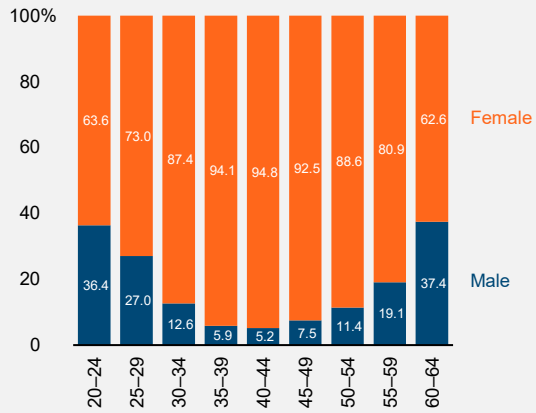
It can be considered that Putrajaya is an anomalous case since the proportion of children is relatively small and there is an abundance of workplace TASKAs, particularly public workplace-based. Terengganu's 12.5% share could be explained by the presence of YPKT owned TASKAs that would be more affordable and targets parents who are in need. Perlis, on the other hand, could have a higher proportion of children in TASKAs due to the higher-than-average number of home-based TASKAs that are registered under JKM and could potentially be more affordable than private-run facilities. However, it is expected that a large proportion of children are receiving informal care (see Box 4.2).

Box 4.2: Informal care in Malaysia

Observations made for informal childcare are based on how women acquire care arrangements for their children. In this context, there are two categories of women namely non-working and working mothers. Non-working mothers are those who are outside of the labour market. Meanwhile, working mothers are those who work either as employers, employees, self-employed or unpaid workers. The difference between these two groups is mainly in the preference of care arrangement acquired. Some mothers prefer to take care of their children themselves, while some would possibly need other parties to undertake the caregiver role efficiently.

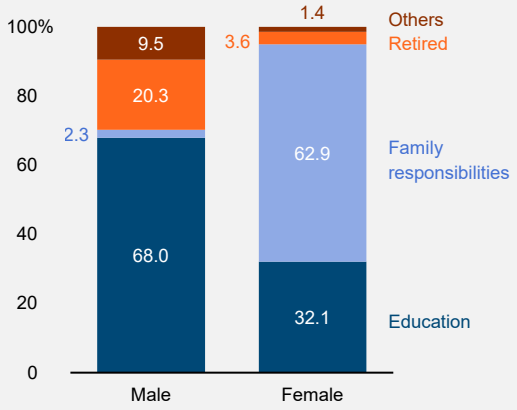
Data on women outside the labour market are used to evaluate the childcare arrangements acquired by non-working mothers. In 2022, about 69.6% of those outside the labour market were women. In terms of age group, more than 80.0% of those outside the labour market were women, especially those between 30 and 59 years old (Figure 4.6). Women aged 35 – 49 made up almost 95.0% of those outside the labour market. These age groups are considered as the prime childbearing years for most women[79].

Figure 4.6: Proportion of the population outside the labour force, by sex and age group, 2022



Source: DOSM

Figure 4.7: Reasons for not seeking work by sex, 2022



Source: DOSM

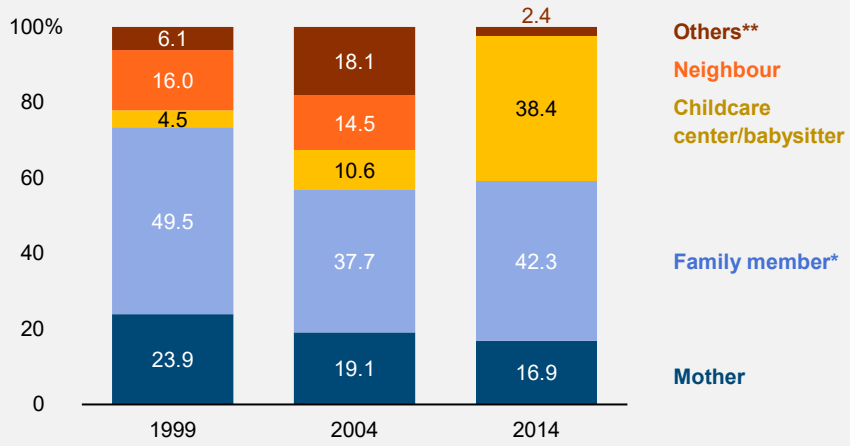
When asked about their reasons for staying outside the workforce, 62.9% of women said that family responsibilities were the main reason for not seeking work, while this was the reason for only 2.3% of men (Figure 4.7). Specifically, when looking at family responsibilities that deter women from being in the workforce, the most recent Malaysian Population and Family Survey (MPFS-5) found that 32.4% of women were faced with childcare problems[80].

[79] Puteri Marjan Megat Muzafar and Hawati Abdul Hamid (2024)
[80] LPPKN (2014)

For working mothers with children below the age of six, Figure 4.8 shows that this group preferred informal arrangements such as by the parents or the child's grandparents (42.3%) compared to nurseries (14.4%)[81]. The trend for this type or arrangement has been consistently high since 1999 until 2014. Working mothers also opt to take care of their children by themselves and although this has arrangement has faced a decline in popularity since 1999, it remains relatively higher than many other types of arrangements, including nursery care.

The share of more formal arrangements, which includes both nurseries and babysitters has increased over time from 4.5% in 1999 to 38.4% in 2014. However, this increase in share has been driven by a preference for babysitters (20.4%).

Figure 4.8: Childcare arrangements by working mothers, 1999 – 2014



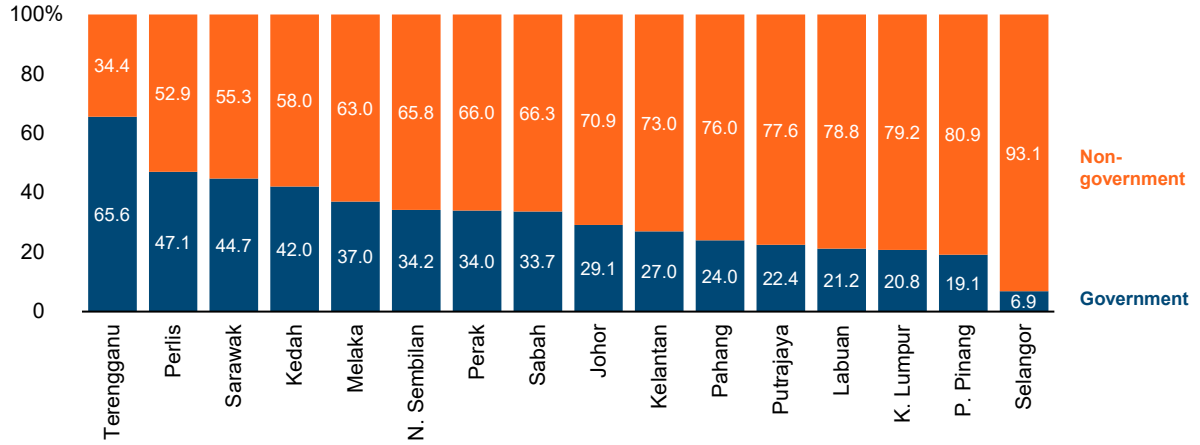
Note: *Family members includes husband, parents, parents-in-law, relatives (living together and elsewhere) and older siblings; **Others includes maids, mother's friends, no caregiver and other persons
Source: LPPKN (various years)

Based on these findings, informal childcare provisions can be derived and observed. Working mothers require a strong support system, which is from their family members, in order for them to enter the labour market. These include their husband, parents, parents-in-law, other relatives and their older children. Neighbours, maids and mothers' friends used to play an important role in providing childcare services to working mothers. However, their relevance has diminished significantly possibly due to changing lifestyle and social norms. Ultimately, these care arrangements without payment—i.e., excluding childcare centres/babysitters—represent informal care provisions.

In line with the data that shows a mainly non-government driven market for TASKAs, it can be seen that a large proportion of children in most states were enrolled in private facilities (Figure 4.9). The exception to this trend would be Terengganu. In Selangor, there was very little enrolment of children in governmental TASKAs.

[81] LPPKN (2014)

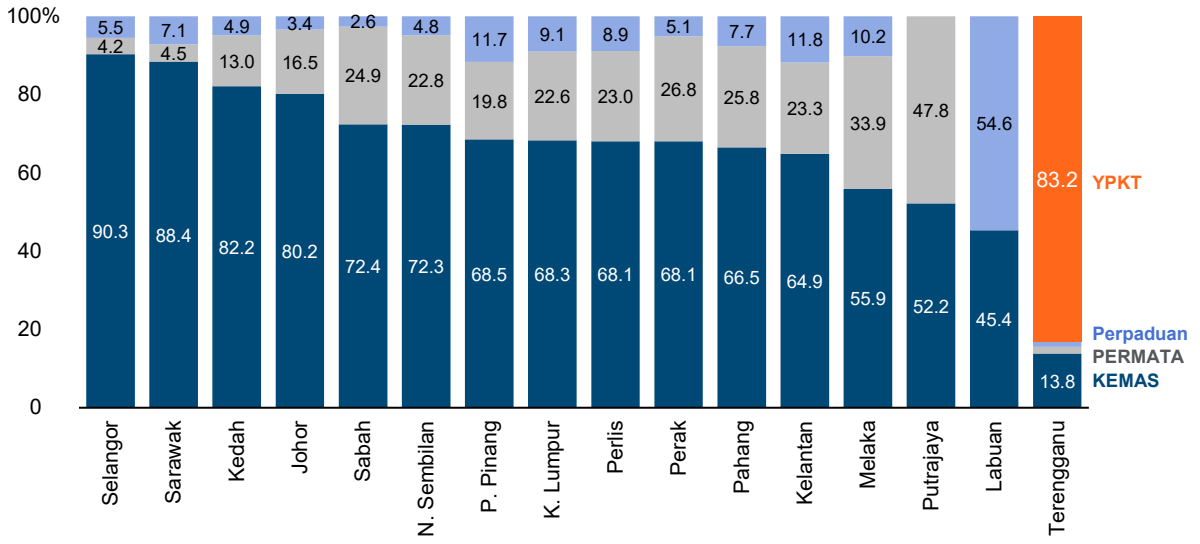
Figure 4.9: Number of children enrolled in government versus non-government TASKAs, by state, 2022



Source: NCDRC (2022)

The postulation on the role of state delivered care promoting the enrolment of children in TASKAs for Terengganu is manifested in Figure 4.10, where the largest proportion of children in the state were enrolled in TASKAs under YPKT.

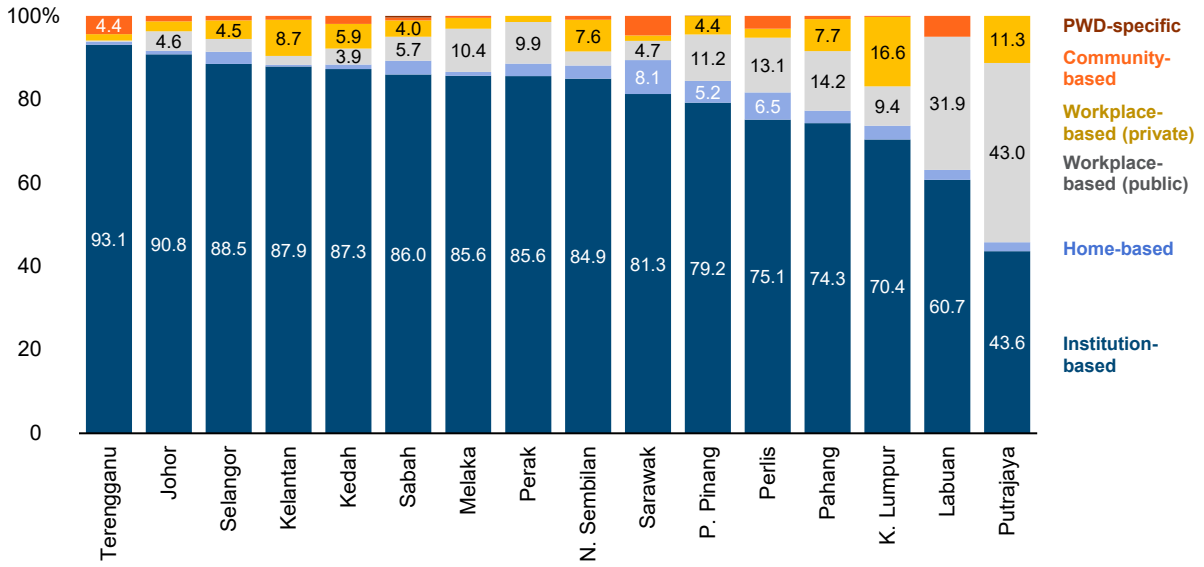
Figure 4.10: Number of children enrolled in government TASKAs, by state, 2022



Source: NCDRC (2022)

Looking at which types of non-government facilities were receiving the most children; it appears that private providers still catered to the bulk of the demand (Figure 4.11). In states such as Kuala Lumpur and Putrajaya, a significant number of children were enrolled in private sector workplace-based TASKAs, reflecting the growing trend of employers recognising the importance of supporting working parents by providing accessible childcare options.

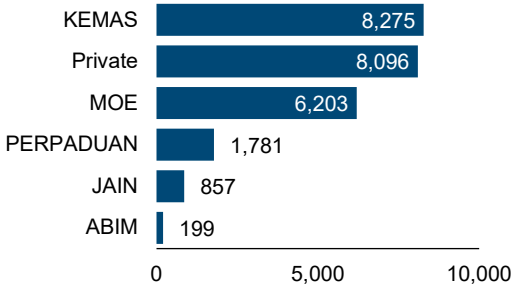
Figure 4.11: Number of children enrolled in non-government TASKAs, by state, 2022



Source: NCDRC (2022)

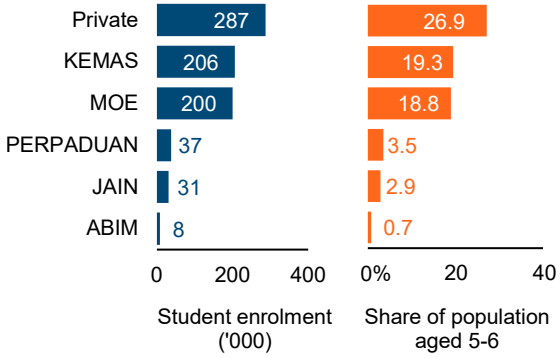
However, the enrolment rate for pre-schools is higher than TASKA[82], as families place greater emphasis on education and development support in line with their children's growth and evolving educational needs. In 2021, the share of children in pre-schools was about 72.1%. In terms of providers, KEMAS is the largest provider of pre-schools, followed by private pre-schools, MOE, JPNIN (the provider of TASKA Perpaduan and classified at PERPADUAN in the relevant figures), Jabatan Agama Islam Negeri (JAIN), and Angkatan Belia Islam Malaysia (ABIM) (Figure 4.12)[83]. By the share of students, about 26.9% of children in pre-schools were in private, 19.3% of students in KEMAS pre-schools, 18.8% in MOE pre-schools and about 7.1% in other pre-schools (Perpaduan, JAIN & ABIM) (Figure 4.13).

Figure 4.12: Number of pre-schools, by agency, 2021



Source: MOE & DOSM (2021)

Figure 4.13: Number of student enrolment and share of the population aged 5-6, by agency, 2021



Source: MOE & DOSM (2021)

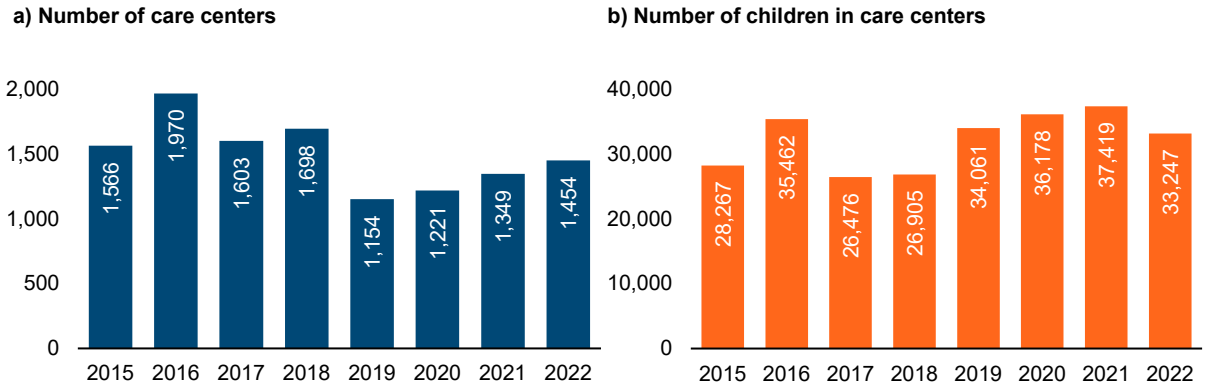
[82] For pre-schools, the main authority is MOE with the most recent year for their reporting being 2021

[83] It should be noted that there may be other providers of pre-schools in Malaysia that have not been included by MOE, perhaps due to the relatively smaller scale of their provision.

Most pre-schools are operated half-day, which means that the children require a separate arrangement of care after their normal pre-school hours. Thus, there are specific care centres that focus on after-school childcare for pre-school going children, more commonly known as transit care centres. In 2022, there were 1,454 such transit care centres (Figure 4.14a), catering to 33,247 children (Figure 4.14b). Out of this number, about 1,080 were privately registered centres (74.2%), while 270 were run by NGOs.

Figure 4.14 also illustrates that these transit care centres appear to have been impacted negatively by the pandemic, falling by 32% between 2018 and 2019. As of 2022 the number of registered transit care centres have yet to return to pre-pandemic levels, despite the current number of children being higher. Between 2021 and 2022 there was also a drop in number of children enrolled in transit care centres, potentially being cared for informally or in unlicensed centres.

Figure 4.14: Number of transit care centres and number of children in the centres, 2015 – 2023



Source: NCDRC (2022)

4.2. Long-Term Care

The analyses in Section 4.2 and 4.3 primarily draw on data from reports by JKM as well as data published in its website, unless cited otherwise. This data covers only registered care facilities, residents and caregivers. The latter two are not provided on a granular level. For the majority of the analyses, we utilise the most recent data published from JKM, specifically from the latest available year, either 2022 or 2024.

LTC facilities for dependent elderly and PWD in Malaysia are either operated by the government, private entities or NGOs. The former constitute a smaller proportion of the facilities and are limited to those who qualify for welfare care. As discussed earlier in Section 3, government provisions for elderly LTC consist of two types of facilities, Rumah Seri Kenangan (RSK) and Rumah Ehsan (RE).

In 2022, there were only eight RSKs and two REs operating throughout the whole of Malaysia, as illustrated in Figure 4.15[84]. Two RSKs, RSK Bedong in Kedah and RSK Johor Bahru in Johor, were reported to have been demolished and were being rebuilt in 2022. Perak has the highest number of these welfare LTC facilities, with three RSKs in the state. Comparatively, Sabah and Sarawak have no RSKs nor any REs, indicating a significant gap compared to the Peninsular states[85].

Over 1,000 elderly people benefited from RSK facilities in 2022 (versus a total elderly population of 2.4 million) but it should also be noted that the occupancy capacity of these RSKs appear to be quite limited. The highest number of occupants in one RSK was 205, with some RSKs such as RSK Seri Iskandar in Perak only reporting 93 residents in 2022. On the other hand, the combined occupancy of both REs in Malaysia in 2022 was only 203. The low number of elderly benefiting from REs could be due to the fact that they are only provided to destitute elderly who are sick, thus requiring more intensive care.

For PWDs, the government provides seven Taman Sinar Harapan (TSH) throughout Peninsular Malaysia, again with no centre operated by JKM in Sabah and Sarawak (Figure 4.15). As at 2022, TSHs housed 798 PWDs with individual facilities having an occupancy ranging from below 50 (TSH Ziyad Zolkefli, Cheras) to approximately 180 residents (TSH Kuala Kubu Bharu, Selangor). PWDs can avail themselves of TSH for three years or until they turn 18.

Figure 4.15: Distribution of government LTC facilities, 2022

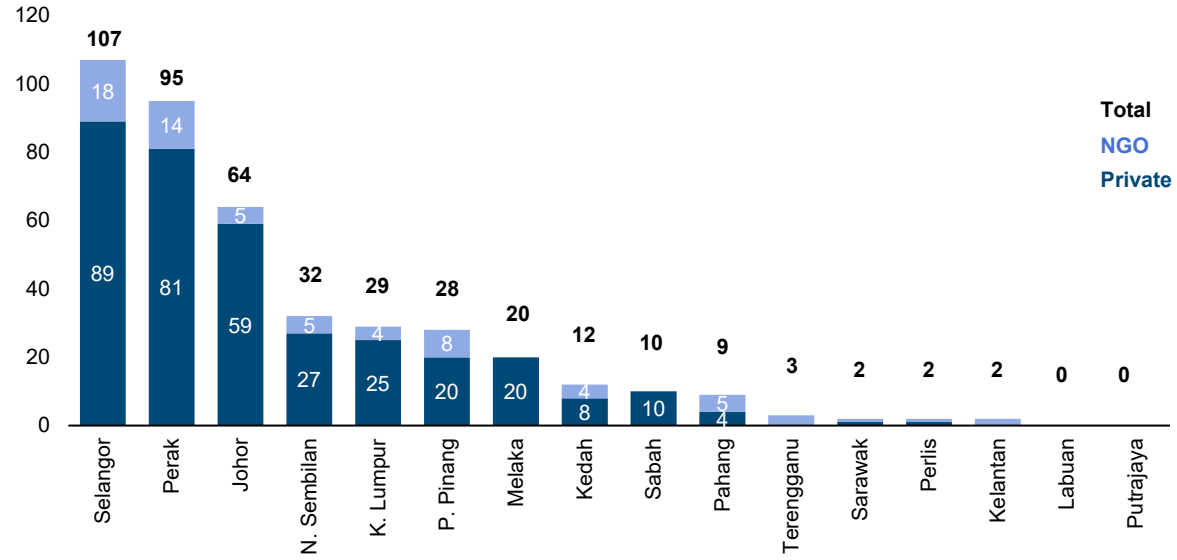
Source: JKM (2023)

[84] JKM (2023)

[85] However, it should be noted that state-provided LTC facilities may exist in these states, and others, although we are unable to identify them based on the most recently available JKM reports and database. For example, the JKM Sarawak website lists RSKs in Kuching and Sibu but the 2022 JKM Statistics Report does not include these RSKs.

With such a small number of government facilities in the country, LTC has become mainly driven by private sector and NGOs. Overall, there were 415 registered LTC centres for elderly in Malaysia in 2024. When broken down by state, the distribution of facilities was not even (Figure 4.16). Selangor had the highest number of facilities, accounting for 25.7%. On the other hand, Labuan and Putrajaya had none while Perlis, Kelantan, and Terengganu had fewer than five facilities. This suggests that states with no or lower number of facilities rely more heavily on unpaid carers, informal or unregistered care centres for the dependent elderly.

Figure 4.16: Distribution of non-government LTC facilities for elderly, by state, 2024

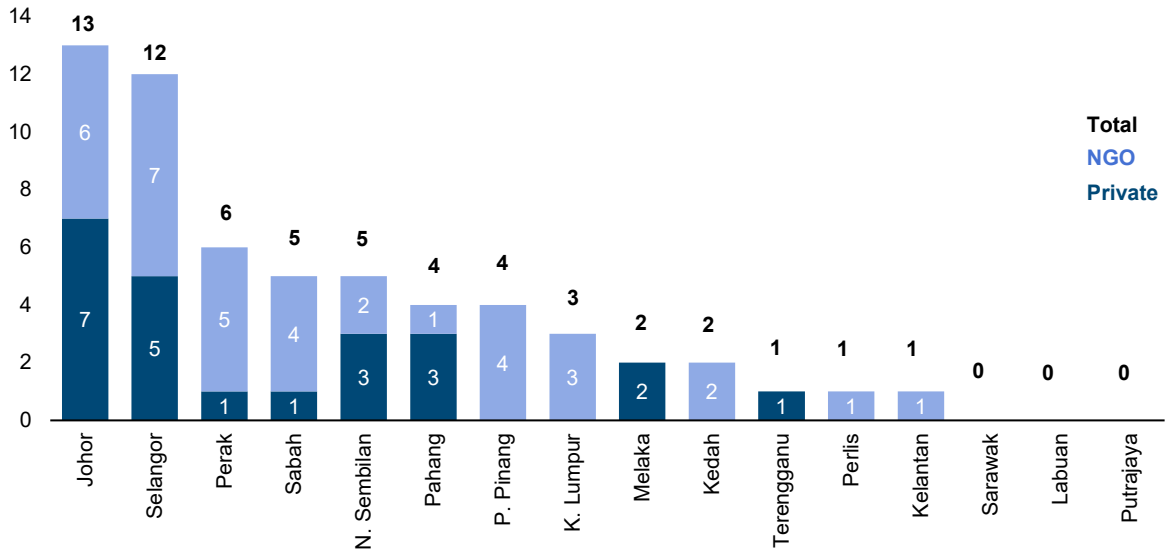


Source: JKM (2024)

A closer look at the breakdown of provider type in each state reveals that private providers dominate elderly LTC services (Figure 4.16). In Melaka and Sabah, all provision is solely private, whereas in Terengganu and Kelantan it is entirely NGO-driven. This reliance on private providers in Sabah is particularly concerning, as the state lacks any welfare institutions offering LTC.

For PWDs, the number of LTC facilities provided by the private sector and NGOs is relatively limited, with fewer than 15 facilities across all states (Figure 4.17). Similar to elderly care, Kelantan, Terengganu and Perlis all have only one registered facility available, while Sarawak, Labuan and Putrajaya do not have any at all.

Figure 4.17: Distribution of non-government LTC facilities for PWDs, by state, 2024



Source: JKM (2024)

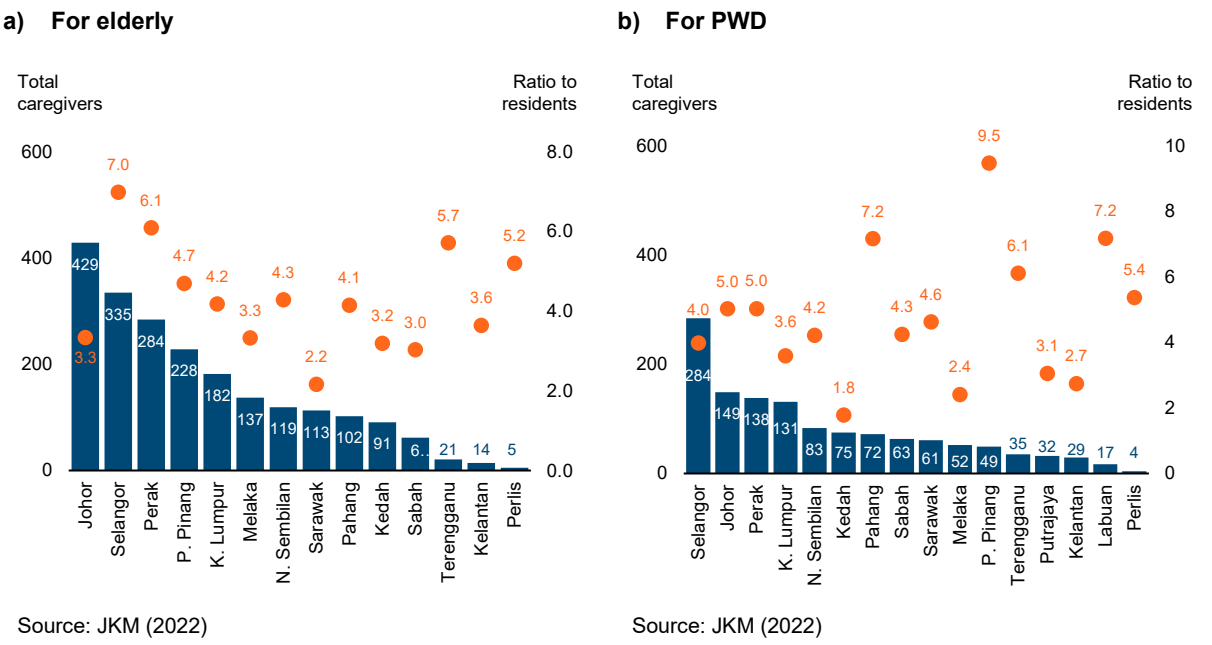
When broken down by providers, for PWDs NGOs constitute the majority of LTC providers in most states (Figure 4.17). In Pulau Pinang, Kuala Lumpur, Perlis and Kelantan, all LTC facilities for PWDs were provided by NGOs. In Melaka and Terengganu, only private providers were involved in providing LTC.

There was also a disproportionate supply of caregivers for the elderly according to state as shown in Figure 4.18a. Johor has the highest number of caregivers at 429 whereas Perlis only has five caregivers. The latter is probably due to there being only one non-government facility registered under JKM. According to JKM, registered facilities should have a carer to care recipient ratio of 1:4 for bedridden elderly and 1:18 for healthy elderly. However, in most states, there is a caregiver to care recipient ratio of more than 1:4, with Selangor having one caregiver provide care for almost seven residents (1:7)[86].

For PWDs the ideal ratio is 1:4 for bedridden PWDs and 1:10 for other PWDs (Figure 4.18b). As of 2022, Selangor reported the highest number of caregivers at 284 with a carer to care recipient ratio of 1:4. Perlis yet again reported the lowest number of caregivers, at four. While all states are still below the 1:10 threshold, 50.0% of states had a ratio higher than 1:4. The latter would be a more important ratio given that LTC facilities would most likely involve PWDs who are severely limited in their ADLs.

[86] These numbers do not give a full breakdown of caregivers per facility and more research is needed to understand the occupancy of each facility and the burden of care work on care actors in each state

Figure 4.18: Caregivers and ratio to residents of LTC facilities, by state, 2022



A caveat to this finding is that the number of caregivers is not reported according to whether they were in day-care or LTC facilities thus this may not necessarily be an accurate depiction of caregiver supply in each state.

Touching briefly on the topic of cost, it was reported that the government spent around RM40 million on institutional care under JKM with a per person cost of RM1,400 per month on necessities including food, clothing and medication[87]. This appears to be a rise from the reported spending in 2012 where close to RM33.0 million was spent on residential and nursing care. These costs would also vary depending on the intensity of care needed[88].

Although studies on exact costs of living in an LTC facility provided by the private sector and NGOs are scarce, there have been reports of the average cost of an elderly person receiving care in a private facility ranging from RM1,500 to RM3,000 per month[89]. Nursing home care was reported to be slightly higher at RM4,000 per month at minimum[90]. Considering the fact that the majority of elderly care in most states are provided for by the private sector, this issue of affordability may be a barrier towards the provision of care in Malaysia. Less is known about the cost of LTC for PWDs and further research is needed to ascertain the affordability of this category of care.

[87] Malay Mail (2022)
[88] Syazreen Niza Shair and Purcal (2021)
[89] Syed Zahiruddin Syed Musa (2024)
[90] The Edge (2017)

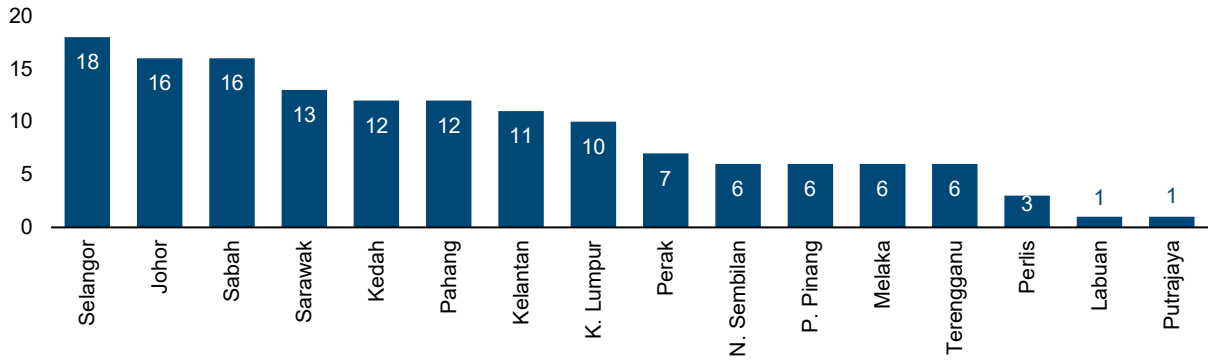
4.3. Social Support

Government-based social support within facilities

Social support, particularly for the elderly and PWDs, is done at a much larger scale in Malaysia as compared to LTC, potentially due to the cost-effectiveness of implementation. While LTC is mainly driven by the private sector and NGOs, the government of Malaysia has had a much bigger role in delivering short-term programmes for social support.

As discussed in Section 3.3, a major initiative by KPWKM to help the elderly within the community is the Pusat Aktiviti Warga Emas (PAWE). In 2024, JKM reported there being 144 PAWEs across the country, including in East Malaysia. The government has previously set a goal of "One PAWE, One Parliamentary Constituency"[91]. Figure 4.19 illustrates the distribution of PAWE across states in Malaysia as of 2024. Selangor has the highest number of PAWEs at 18 but states such as Sabah and Sarawak have also recorded quite a substantial number of PAWEs.

Figure 4.19: Distribution of PAWEs, by state, 2024



Source: JKM (2024)

However, given the rise in ageing population and the geographical landscape of some states that may serve as accessibility barriers, these numbers may need to increase to meet the needs of the elderly who wish to age healthily in place. Even currently with Selangor having 18 PAWEs, this is still lower than the number of parliamentary constituencies in the state. The quality of care provided in these PAWEs also may vary as reported by KPWKM in 2019 where some facilities may have comprehensive services whereas others lack manpower and resources[92].

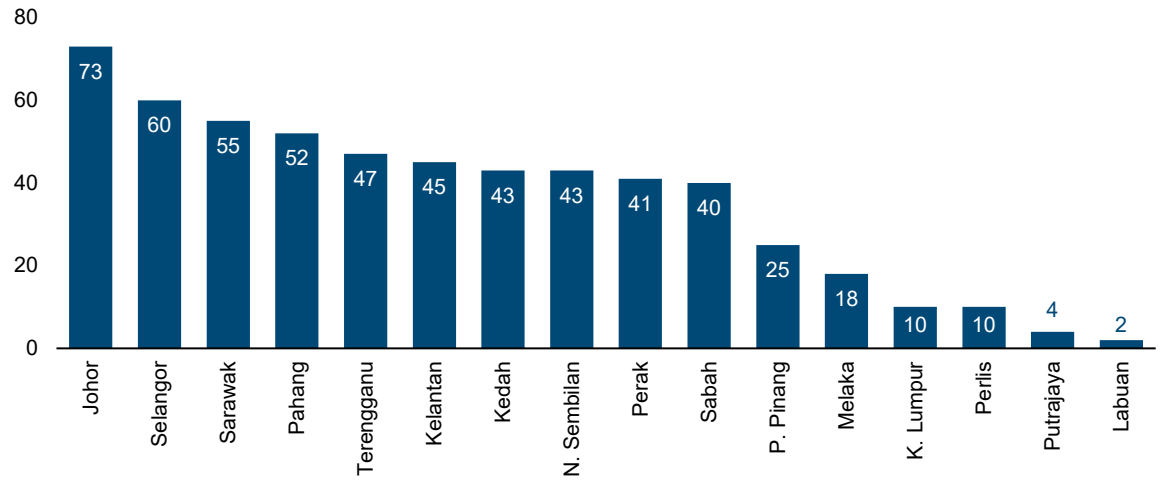
Other smaller scale initiatives by the government for the elderly include Unit Penyayang Warga Emas (UPWE) which supplies nine vehicles across the states of Perlis, Selangor, Melaka, Johor, Pahang, Terengganu and Kelantan[93]. This appears to be insufficient to cover the needs of the elderly who require transportation even within the state itself and it is unclear why there is a focus on only these states. In terms of Independent Living Centres (ILC), there are six in total in five states and are delivered by different entities including NGOs and universities.

[91] Bernama (2019)
[92] Syed Zahiruddin Syed Musa (2024)
[93] Pangkalan Data Perlingungan Sosial (2021)

On the other hand, social support for PWDs by the government focuses on helping them obtain work opportunities and training. Community-based Rehabilitation Centres (*Program Pemulihan dalam Komuniti* or PPDK) across the nation provided training for PWDs with different types of disabilities. In 2022, the main participants of this programme were those with physical disabilities (2,360) and other disabilities (1,717) while the lowest participation was from those with speech disabilities (110)[94].

Figure 4.20 shows the number of PPDKs in each state for the year 2022, with most of these being delivered by volunteers based in community centres (80.0% of volunteers were centre-based instead of home-based). States like Kelantan and Kedah which have a high PWD to population burden show a good number of PPDK, but the programme implementation is quite low in Perlis which had the third highest share of PWD to population.

Figure 4.20: Distribution of PPDKs, by state, 2022



Source: JKM (2022)

Besides PPDKs, the government also provides training via Industrial Training and Rehabilitation Training Centre (*Pusat Latihan Perindustrian dan Pemulihan* or PLPP) which, in 2022, provided industrial training to 80 trainees. These trainees consisted of 21 females and 59 males. In terms of Bengkel Daya, Malaysia only has two facilities which provides jobs to 78 residents.

It is unclear whether the outcomes of these programmes are directly beneficial in ensuring that PWDs are employed. According to the PWD Statistics Report 2022, PWD employment in Malaysia's private sector grew from 1,377 in 2021 to 3,186 in 2022 although employment in the public sector remained stagnant. The average income for households with PWDs was reported to be RM5,679 whereas the average expenditure for a PWD household was reported to be RM3,974. However, this figure is likely to vary across different states[95].

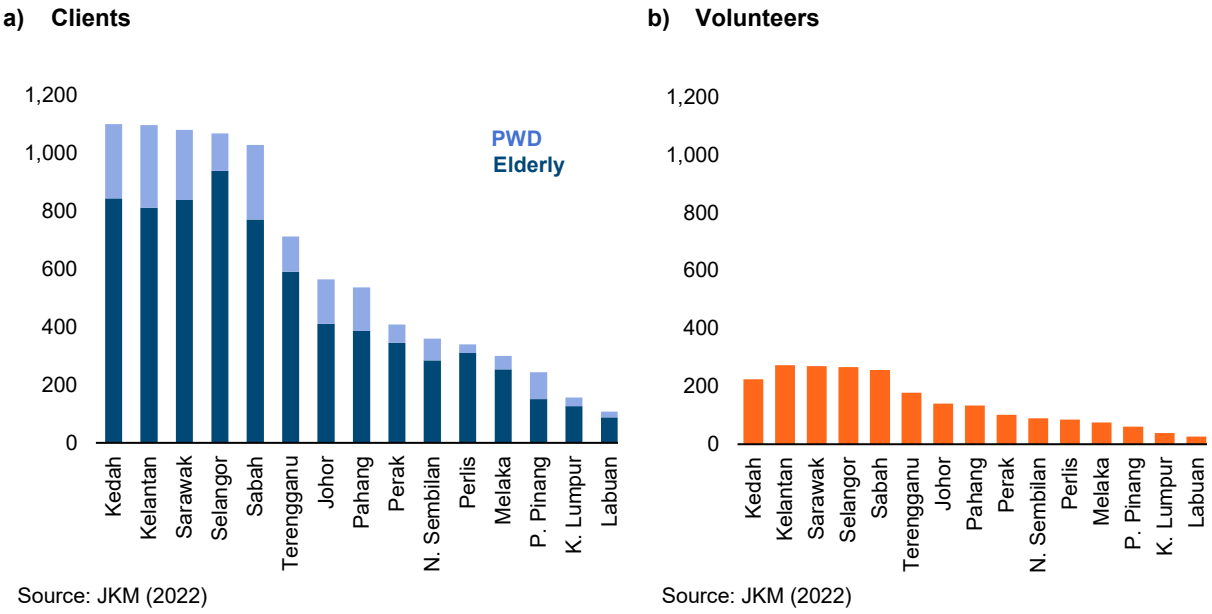
[94] JKM (2023)
[95] DOSM (2022)

The government also provides TASKAs specific for PWDs below the age of four and there are 13 such day-cares in the country. The majority (62.0%) of these TASKAs cater for learning disabilities, while some focus on hearing, visual and physical disabilities respectively. These TASKAs are distributed throughout the country with the highest number located in Sabah (three), followed by Kelantan (two). The management of these TASKAs falls under specific organisations within the state, mostly NGOs.

Government-based social support at home

For the Home Help Services (HHS) programme provided by the government, JKM has employed over 2,000 volunteers to deliver at-home care to both elderly persons and PWDs. As shown in Figure 4.21a, Kedah, Kelantan and Sabah have a large number of clients for the HHS. These states have also been shown in previous sections to have a smaller number of facilities for both elderly and PWD. The demand for HHS is mainly driven by the elderly population in all states.

Figure 4.21: Number of clients and volunteers for HHS, by state, 2022



Source: JKM (2022)

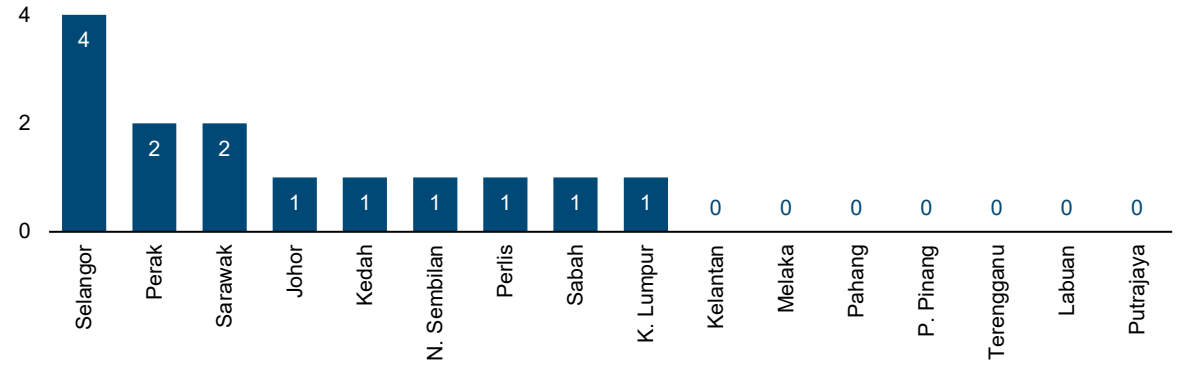
Source: JKM (2022)

In terms of manpower (Figure 4.21b), the number of volunteers in most states in 2022 was less than 300, and these volunteers were shared between both elderly and PWD clients. However, based on the author's calculations, JKM has ensured that for all states there is a ratio of volunteer to client ratio of 1:4, with the exception of Kedah which has a ratio of 1:5. As the number of elderly who wish to age in place grows in Malaysia, HHS appears to be a plausible solution to providing care at-home.

Private and NGO-driven social support

Private companies and NGOs provide a very small proportion of elderly day-care facilities, only 14 overall in 2022. As shown in Figure 4.22, all states have less than five private or NGO-run day-care facilities and seven states, including Labuan and Putrajaya, have none at all. In this category of elderly facility, neither private nor NGOs have dominance, and it is postulated that perhaps this is due to the relative abundance of PAWE within all the states.

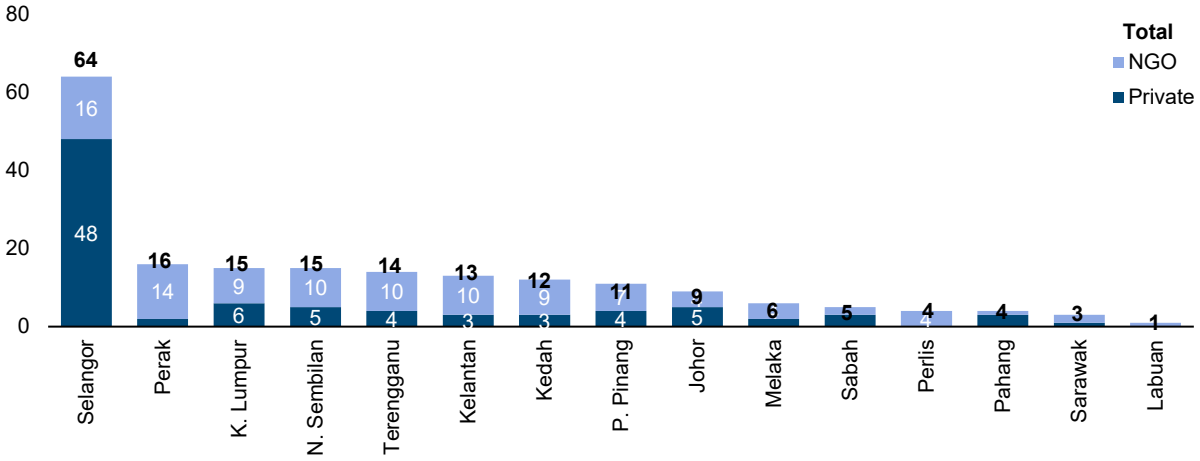
Figure 4.22: Distribution of non-government day-care facilities for elderly, by state, 2022



Source: JKM (2022)

In contrast, private companies and NGOs in Malaysia focus on providing non-residential facilities to PWDs. In 2022 there were 161 of these day-care facilities for PWDs. Figure 4.23 shows that all states in Malaysia have at least one day-care facility provided by private or NGOs. However, Kelantan and Perlis appear to have less than five day-care facilities and given their high PWD to population share there is probably a high reliance of PWDs on public initiatives and programmes.

Figure 4.23: Distribution of non-government day-care facilities for PWDs, by state, 2024



Note: There is an unexplained discrepancy in the data for Putrajaya from the JKM report and the JKM registration website. Thus, Putrajaya was omitted from this graph.
Source: JKM (2024)

Additionally, this paper did not further explore the breakdown of the type of disabilities each centre caters for thus it is difficult to ascertain whether there is sufficient supply for each category. Given that there are seven types of disabilities, we postulate that there is a need to boost the supply of care facilities, whether from the public, private or community, especially for states with less than five centres.

Figure 4.23 also shows that the majority of day-care providers for PWDs are NGOs. For Labuan and Perlis, all non-government day-care centres are run by NGOs whereas for Selangor, Pahang and Sabah, the majority of providers are private. Despite the latter states being mainly private, they also have a larger number of PAWEs, thus potentially meeting the needs of the elderly community, given that these PAWEs are fully functioning.

5. Gaps in Care Provision

Despite efforts to provide care services, significant gaps remain in Malaysia's care system. This section explores the challenges in care provision, particularly in terms of accessibility, affordability and quality. It assesses how these gaps affect children, the elderly and PWDs, particularly the most vulnerable within the groups and highlight the barriers that prevent equitable access to care services. The analysis underscores the need for improved policies and more robust systems to bridge these gaps and ensure comprehensive care for all segments of the population.

5.1. Availability and accessibility

Imbalanced supply of resources

Although there appears to be numerous childcare centres available to the population, the question around accessibility remains. Childcare in Malaysia is mainly private-driven, raising the issue of both abilities to access and cost. In fact, less than 10.0% of children in most states were enrolled in childcare facilities in Malaysia. It is unclear whether the remaining children are cared for at home or in unlicensed childcare facilities. Workplace-based TASKAs also remain quite low in general, especially for private workplaces, indicating that there is still unmet demand for working parents who require easily accessible childcare.

For the elderly, there is still a relatively small number of dedicated facilities that cater to the needs of this population group. There is also an obvious split between private-driven residential LTC and government-driven social support services in line with Malaysia's policy shift towards more community-based care alongside changing cultural preferences to age in place[96]. The government has made good efforts to establish community-based and home-based social support in all states, including Sabah and Sarawak. Low-income states such as Kedah, Kelantan and Sabah have shown the highest utilisation rate of such home-based services, perhaps as a result of the lack of LTC there. However, there have been reports of manpower and quality issues across different PAWEs in addition to the fact that the home-based services are quite limited, only providing care for one hour at a minimum of once a week[97].

At the same time the private market has increased its provisions of LTC for the elderly in the nation, indicating a rising demand, especially in more urban states such as Selangor, Johor and Kuala Lumpur. In 2022, almost 10,000 elderly persons availed themselves of these LTC facilities, illustrating that there remains a demographic that needs residential care. There is currently a "missing-middle" group of elderly who perhaps have a degree of disability due to the natural process of ageing but are still considered healthy, i.e. not bed-ridden.

[96] ISIS (2024); Syazreen Niza Shair and Purcal (2021)
[97] Syed Zahiruddin Syed Musa (2024)

In 2018, the National Health and Morbidity Survey (NHMS) found that 17.0% of those above the age of 60 had a dependency for activities of daily living (ADL) and 42.9% were only dependent for independent activities of daily living (IADL) (described in Section 3)[98]. While the latter group may only require social support, the former would need more intensive care to ensure they live decent lives.

For PWDs, there is little focus on LTC by both the private and public sector, with only one type of residential facility provided by the government. Instead, there is a strong government role in providing social support for PWDs to encourage their economic productivity and integration into society. While the government has successfully expanded these social support centres across all states, there is still room for additional investment. For example, although Perlis has the third highest share of PWD to their population, there are only 10 training centres in the state. In 2022, there were only 80 trainees that benefited from training under PLPP across Malaysia, showing the current limitations in scale.

Lack of awareness

Beyond just the *availability* of facilities, access to care is also determined by awareness within the population. Perhaps less so a barrier for childcare services, the uptake of LTC and social support for elderly and PWD may be influenced by whether or not they are aware of such provisions.

In 2018, it was reported that 30.8% of Malaysians above 60 perceived having poor social support. This perception was particularly prevalent among those who were single and of low-income[99], meaning adults living alone and lacking information passed through other members of the family may not be benefiting from government initiatives to provide social support. A small-scale local study published in 2022 that interviewed elderly people attending PAWE also found that there was also a lack of understanding among the children of elderly people on the purpose of PAWE. Being prohibited by their children has been cited as a reason why some elderlies were not able to attend events and activities at PAWEs[100].

This lack of awareness is also seen when it comes to PWD initiatives. A case study by IDEAS looking at the financial burden of parents of autistic children in Malaysia found that some parents were not aware of financial support available[101]. Although there has been an effort to create centres called Pusat Khidmat Setempat by the government to provide a one-stop-shop for PWD services, including registration and guidance, there have only been two such centres established throughout Malaysia. Additionally, registration as a PWD in Malaysia is currently on a voluntary basis and even though registration facilitates the provision of support, the stigma and discrimination faced by PWDs may deter some from registering as such[102].

[98] MOH (2018)
[99] MOH (2018)
[100] Faizah Hanim Zainuddin, Mashitah Hamid, and Haris Abd Wahab (2022)
[101] Chandran (2016)
[102] Siti Marshita Mahyut (2017)

5.2. Affordability

This paper has shown that the care landscape in Malaysia is highly privatised, and this introduces the issue of affordability of care centres. This is especially pertinent to ECCE and LTC, where the government plays a very small role in provision of care for those aged four and below as well as for the elderly who require residential care. For LTC, the range of costs between RM1,500 to RM3,000 would be particularly burdensome for the majority of Malaysian families[103]. In 2023, it was estimated that the minimum monthly expenditure for a married couple with one child in Lembah Klang was RM5,980, with over 10.0% of this being contributed to childcare costs. The reported minimum expenditure for childcare specifically also varied between states, ranging from RM540 in Kuching, Sarawak to RM600 in Georgetown, Pulau Pinang[104]. Combined with the added responsibility to shoulder the costs of LTC for elderly parents, a considerable financial strain is expected in the absence of any subsidisation or long-term care financing schemes.

It could be argued that these costs can be lowered through enrolment of the elderly in social support services such as day-care centres instead of residential facilities. However, currently existing elder care facilities are not equally distributed across states. Elderly people have to compete for the few PAWEs available and in some states such as Melaka, Kelantan and Terengganu there are no non-government day cares available. Due to the limited nature of these day-care facilities, the costs for private facilities are often expensive as well[105]. Home Help Services that are delivered by volunteers to both elderly and PWD, although cost-effective, may not have reached the scale needed to care for a substantial proportion of the Malaysian population.

For PWDs, there is more focus from the private and NGO sector on provision of day-care social support services. However, some states with a high PWD to population share have less than five such facilities. This small market would result in high prices for enrolment and a competition for cheaper public initiatives and programmes. Households with PWDs in Malaysia have been shown to spend up to 27.5% of their monthly income on disability-related expenses[106].

On top of the financial expenditure on facilities, there is also the invisible cost exerted on caregivers of children, elderly and PWDs. For those who are in the so-called "sandwich generation", where working adults have to shoulder the responsibility of caring for both young children and ailing parents, there appears to be the need to decide whether to spend on care or not. In the case of the latter decision, there is also a cost associated with healthcare loss to the caregiver as well as impacts on their careers and earning potential. A study in the United States found that caregivers were more likely to develop chronic illnesses, mental issues, present with absenteeism or presenteeism and also have a reduction in their productivity at work[107].

[103] Syed Zahiruddin Syed Musa (2024)
[104] KWSP (2023)
[105] Syed Zahiruddin Syed Musa (2024)
[106] Ruzita Mohd Amin and Nur Syuhada Md Adros (2019)
[107] SOA Research Institute (2023)

The issue of affordability of care centres is not simply a matter of the private sector making profit. Care providers struggle with high costs of operations including utility bills, workers' salaries and rent alongside maintaining a good carer-to-recipient ratio and bearing the costs of training personnel to deliver quality care[108]. Thus, keeping prices low is becoming difficult, particularly for centres that have registered with JKM and are required to adhere to strict regulations[109]. Despite government provisions of subsidies to parents in a bid to improve affordability, the schemes do not benefit some subsets of parents, requiring review and expansion.

5.3. Quality

Quality control and enforcement of standards in Malaysian care facilities still has room for improvement[110]. It has been previously highlighted that there are currently a few legislations that are relevant to the care economy, but these are fragmented and inconsistent[111]. There is also a heavy reliance on KPWKM to govern the key areas of the care economy. This has created a stigma that care is mainly a women and welfare issue but in reality, this is a cross-cutting issue that has far-reaching consequences across areas including, but not limited to, human resources and economic growth.

According to the World Bank, the enhancement of public welfare homes requires a review and introduction of annual targets to monitor performance on a yearly basis. Although JKM provides yearly reports of the programmes delivered, these reports are one-dimensional and only provides statistics on enrolment in programmes and available supply of resources. They do not specifically disclose outcomes from said programmes and does not provide measures of satisfaction of recipients or participants.

Malaysia has seen a rise in neglect and abuse cases occurring in care centres in recent years. In response to this many groups have called for an enhancement in quality of services, particularly related to the human resources aspect of care. However, this requires investment in a well-trained and well-compensated workforce, which, as discussed in Section 5.2, is becoming a hard task for care providers amid rising costs and demand for lower fees. The issues of care workforce are discussed further in another working paper in this series of Care research conducted by KRI, "Recognising and Rewarding Care Workers"[112].

[108] Nor Azah Abdul Aziz et al. (2021)
[109] New Straits Times (2022)
[110] UNDP (2024)
[111] ISIS (2024)
[112] Hafiz Hafizi Suhaimi and Hawati Abdul Hamid (2024)

6. Conclusion

Ultimately, there is still substantial progress that needs to be made in order to achieve an equitable ecosystem of care. Although Malaysia has made commitments towards ensuring the wellbeing of children, the elderly and PWDs, current provisions are currently insufficient, and many segments of the population still lack adequate care. This paper has highlighted a gap between demand and supply within the care sector, uneven care provisions across the nation and fragmented governance that limits effective care delivery. It is crucial that strategic investments be made in both public and private care infrastructure, workforce development and financial support mechanisms.

Firstly, **promoting growth of the care market** needs to be prioritised**.** Malaysia is projected to undergo a dramatic increase in the elderly population and the burden of dependents is expected to boost the demand for care provision. Thus, increased investment is required to ensure enhanced capacities, particularly in states with higher-than-average care burden. The government should look into addressing areas including care infrastructure, care-related social protection, care services and employment-related care. Investments can also be multi-sourced, not only relying on government funding but also by incentivising private sector investment and capitalising on the potential of government-linked investment companies.

Second, **address disparities by expanding government support.** LTC provision has typically been limited by the government in the case of the elderly and PWDs. For children, more focus is given to those of preschool age whereas care for very young children with more care needs is mostly provided for by the market. Disparities in public care provision, particularly in rural and undeserved regions, need to be addressed through development of more infrastructure to increase access to vulnerable populations. Additionally, financial assistance in the form of care subsidies or cash vouchers should be expanded to both low-income and middle-income families to promote more access to formal care services.

Third, **strengthen the Care Framework.** Beyond spurring the growth of the care economy, the government needs to develop a cohesive and integrated long-term framework for care provision. Through effective planning of resources as well as synergistic collaboration between government, NGOs and the private sector, Malaysia can enhance the availability and quality of care services to be able to meet the needs of the population. This includes strategising the expansion of the care workforce, balancing provision of government versus non-government initiatives and improving care needs assessment for the population.

With the increasing burden of dependents coupled with a shrinking working-age population, Malaysia needs to innovate and establish strong foundations for care that enshrines availability, affordability and quality.

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