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Recognising and Rewarding Care Workers

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Khazanah Research Institute

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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 examine the situation of Malaysian care workers, focusing on both unpaid caregivers and paid care workers. It explores key elements such as the demographic characteristics of care workers, education and training programmes, job market dynamics, and decent work initiatives. The insights provide an understanding of the current challenges faced by care workers and suggest policy recommendations aimed at improving the sector. The key findings and policy implications are summarised below:

Key findings

1. Gender Imbalance and Decent Work Deficits in Care

Care work in Malaysia is characterised by significant gender imbalances, with women disproportionately shouldering both unpaid and paid care responsibilities. The majority of unpaid caregivers are women, often caring for family members. Similarly, women also dominate the paid workforce, both in formal and informal settings. The informal care sector, in particular, faces a lack of labour protection, leaving many workers vulnerable to poor wages, limited career advancement, and precarious working conditions. These systemic issues highlight the urgent need for targeted reforms to address gender inequities, improve working conditions, and create more stable and equitable opportunities within care work.

2. Training and Education in Care Work

Strengthening training and educational programmes is crucial for skill development within the care workforce. Currently, gaps exist in formal education and certification for some segments of care-related professions. Fields such as *School & Higher Education, Medicine & Dentistry*, and *Allied Health* are well-represented, offering a wide range of programmes and a strong number of graduates. However, *Social & Welfare* and *Early Child Care & Education* are underrepresented, with more limited overall educational opportunities. Additionally, overall training investment is still low for the care sector, especially in *Residential Care* and *Social Care Work*, compared to the national average.

3. Job Market Trends and Opportunities

The Malaysian care job market presents a mixed picture. The majority of jobs in the *Education* and *Human Health* subsectors are high-skilled, while the *Residential Care* and *Social Care Work* subsectors have a larger share of semi-skilled positions. Nevertheless, the demand for low-skilled jobs in overall care sectors has risen over recent years. This trend suggests that although high-skilled jobs are increasing, the continued demand for semi-skilled and low-skilled care workers may reinforce a perception that care jobs are largely unskilled, despite their essential role and relevance.

Policy Implications

1. Advancing the Decent Work Agenda for All Care Workers

The government must strengthen the Decent Work framework for the care sector by incorporating the 5R principles: recognise, reduce, redistribute, reward, and represent care work. This includes recognising the value of both paid and unpaid care work, reducing the burden on caregivers—particularly women—through supportive policies such as expanding formal care services and redistributing caregiving responsibilities more equitably between men and women. Additionally, both paid and unpaid care work across formal and informal sectors should be rewarded accordingly. Policy priorities should focus on integrating unpaid and informal care work into Malaysia's care economy framework, particularly by ensuring fair wages, improving working conditions, and fostering career growth opportunities for care workers. Strengthening social protections, promoting collective bargaining, and ensuring that care workers' voices are heard in policymaking is essential to improving the overall care work environment.

2. Enhancing Investment in Vocational and Certification Programmes

To raise the standards of care work in Malaysia, it is essential to expand vocational education and certification opportunities for care workers in underrepresented and less regulated subsectors, such as *Residential Care* and *Social Care Work*. Additionally, initiatives to encourage greater employer investment in training would enhance the skills and competencies of these segments of care workers. This will help professionalise their work, improving both the quality of care provided and the workers' job prospects.

3. Promoting Specialised Care Jobs through Innovation and Investment

To strengthen Malaysia's care sector, policy interventions should focus on creating more high-skilled job opportunities by leveraging technological advancements, fostering quality investments, and responding to increasing demand for care services. By encouraging the adoption of innovative technologies, such as digital health tools and remote monitoring systems, the sector can transition toward higher-skilled roles that require specialised training. Additionally, policies that incentivise private and public sector investments in high-quality care facilities and services can attract and retain a skilled workforce.

Conclusion

A comprehensive strategy to strengthen Malaysia's care workforce is essential for advancing both social and economic development. Addressing the challenges faced by both unpaid caregivers and paid care workers requires concerted efforts to enhance education, expand training opportunities, and improve job market conditions. By prioritising the advancement of decent work initiatives and ensuring the recognition and fair compensation of all care work, Malaysia can foster a more sustainable, equitable, and resilient care system. Strengthening the care sector will not only benefit workers but will also support the well-being of families and communities, contributing to the overall prosperity of the nation.

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1. Introduction

In Malaysia, the demand for care services is on the rise, driven by an ageing population, an increasing need for personal assistance assistance and care, as well as persistent demand for childcare. Despite these growing needs, the supply of care services remains inadequate, placing significant pressure on families, particularly women, who often bear the burden of caregiving[1]. Our earlier study titled, "Gender Gap in the World of Work: Status and Progress[2] highlights that women's labour market participation has consistently lagged behind men's, primarily due to family responsibilities linked to unpaid care work. As many families cannot afford the services of paid care workers[3], the responsibility often falls on unpaid caregivers, which has profound social[4] and health[5] implications[6]. Furthermore, paid care workers encounter their own set of challenges, including challenging working conditions, low wages, and limited career advancement opportunities.

Care is inherently a labour-intensive activity, encompassing a wide range of duties that require significant human effort, skills, and dedication. This intensity arises from the need for continuous, personalised attention to meet the diverse needs of individuals requiring care, whether they are children, the elderly, or persons with disabilities (PWDs). The nature of care work involves not only physical tasks but also emotional support, which makes it both demanding and fulfilling. Care work can be rewarding due to the emotional and personal fulfilment that comes from helping others and making a positive difference in their lives. However, it also comes with significant challenges.

The physically demanding aspects of care work can lead to fatigue and strain, as caregivers often work long hours and perform strenuous tasks. Additionally, the emotional burden of providing constant support can result in stress, burnout, and compassion fatigue. Caregivers may face the challenge of managing their own emotional well-being while addressing the complex needs of those they care for. Moreover, care work is frequently undervalued and under-compensated[7], which can contribute to financial and job satisfaction issues.

[1] Puteri Marjan Megat Muzafar and Hawati Abdul Hamid (2024a)
[2] Puteri Marjan Megat Muzafar and Hawati Abdul Hamid (2024b)
[3] Fatimah Abdullah, Siti Hajar Abu Bakar Ah, and Mohd Suhaimi Mohamad (2015)
[4] Social implications refer to consequences due to care responsibilities on caregivers' personal lives, relationships, daily routine and leisure time. Source: Siti Hajar Abu Bakar et al. (2014)
[5] Health implications include physical and mental effects. Source: Suriawati Ghazali et al. (2015)
[6] see Suriawati Ghazali et al. (2015), Fatimah Abdullah, Siti Hajar Abu Bakar Ah, and Mohd Suhaimi Mohamad (2015), Zati Sabrina Ahmad Zubaidi et al. (2020), Tan et al. (2020), Munusamy (2023), Aniawanis Makhtar et al. (2023), Munirah A Taufik et al. (2023), Zuzana Aman et al. (2020) and Nor Shahrina Mohd Zawawi et al. (2023)
[7] ILO (2018)

While traditionally care work has often been unpaid and performed within households, social progress and modern living have created a market for care services, making the work increasingly formalised and compensated. This shift reflects broader changes in societal structures and attitudes towards care work. As more women have entered the workforce and societal norms have evolved, the demand for professional care services has risen.

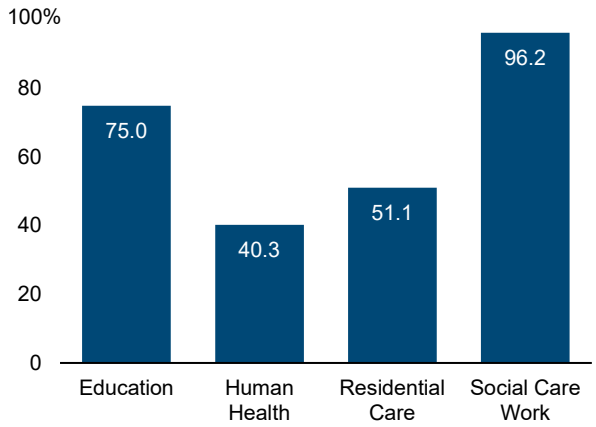
This has led to the development of formal care industries that provide services ranging from childcare and eldercare to specialised support for individuals with disabilities. These industries not only address gaps in unpaid care but also offer more care options, improving the quality of care and providing better support for both caregivers and care receivers.

According to the International Labour Organization, workers in the education, health, and social work sectors are referred to as care workers[8]. It is estimated that there were about 381 million care workers globally, representing 11.5% of total global employment[9]. More women are entering these roles than men, comprising more than two-thirds of the total care workforce. A total of 249 million women are care workers, representing 19.3% of total global women's employment. In contrast, 132 million men are part of the care workforce, comprising 6.6% of global male employment.

The overrepresentation of women in global care workers is also mirrored in Malaysia, where women make up 65.0% of the total care workforce. Across sectors, the proportion of women is higher in *Social Care Work*, at 95.3%; *Education*, at 65.5%; and *Human Health*, at 56.5%.

In addition, the cost of labour relative to total input costs in care subsectors is substantial, reflecting the labour-intensive nature of care service activities. Figure 1.1 shows that the share of labour costs, represented by salaries and wages, exceeds 75.0% for *Education* and *Social Care Work* indicating heavy reliance on labour in these subsectors to provide care services. Meanwhile, the share for *Human Health* at 40.3% is lower relative to others, primarily due to higher non-labour input costs such as medical equipment and technology adoption.

Figure 1.1: The total salaries and wages relative to cost input, by subsector, 2021



Source: DOSM (2022a)

Given the labour-intensive nature of care, it is essential to strengthen the support for care workers by prioritising decent work standards across diverse roles. Care workers are pivotal in delivering high-quality care, and supporting their well-being is crucial not only for the quality of care provided but also as a matter of fair treatment and creating a positive work environment for all workers. Policies that focus on decent work agenda and fair labour practices will help build a sustainable and effective care system, benefiting individuals, families, and society as a whole.

[8] ILO (2018)
[9] Ibid.

1.1. Objective of the study

This working paper is part of studies within KRI's broader research on Gender and Care Work. The objective of this paper is to provide a comprehensive overview of the care workforce from multiple perspectives, including the demographics of paid care workers and unpaid caregivers, care-related education and training programmes, labour market trends and job opportunities, and initiatives to promote decent work in the care sector. These perspectives are crucial for understanding the challenges faced by care workers and caregivers, identifying key issues, and offering recommendations to improve the working conditions and overall support in the care sector.

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

- Department of Statistics Malaysia (DOSM)
- Ministry of Higher Education (MOHE)
- Human Resource Development Corporation (HRD Corp)
- International Labour Organization (ILO)

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

1.2. Organisation of the paper

This paper is structured as follows:

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

- **Section 2: Demographics and Characteristics** explores the demographics of unpaid caregivers and paid care workers, the two main providers of care work. Compensation for labour differentiates these two groups, often leading to different challenges and concerns. This section also examines the wages earned by care workers to assess wage levels and disparities among subgroups within the paid care workforce.

- **Section 3: Skills and Talent Development** explores the availability of care-related skills development programmes within higher education and training institutions. It also evaluates the effectiveness of training and certification programmes based on index scores from the National Training Index as a means to understand the impact of training programmes on the skills and competency of care workers.

- **Section 4: Care Job Market** analyses the labour market for care jobs, shifting focus to the demand side. It includes information on the availability of care jobs, along with trends in job creation and vacancies, offering insights into the supply and demand dynamics within the care labour market.

- **Section 5: Decent Care Work** discusses initiatives and interventions aimed at improving the quality of care work conditions. It explores best practices and international benchmarks, including the ILO's Decent Work framework, to guide Malaysia's efforts in promoting a decent work agenda.

1.3. Key definitions and scope of work

This section defines key terms related to care work to establish the context and scope of the discussion in this paper.

Table 1.1: Definitions for key terms related to care work

Term	Definition
Care work	The provision of physical, emotional, psychological, and developmental support to a care recipient which can be provided directly or indirectly.
Direct care	Personal, relational, and face-to-face caregiving activities include nursing an ill person and feeding and nurturing children in childcare centres.
Indirect care	Tasks that support caregiving but may not entail personal, relational and face-to-face interactions such as cleaning or cooking performed by hired domestic workers or cooks in the care centres.
Paid care workers	Individuals who receive monetary compensation for providing care services. Examples of paid care workers include nurses, early childhood educators, and social workers.
Unpaid caregivers	Individuals who provide unpaid care, often family members, neighbours, friends or volunteers, who assume this responsibility voluntarily or due to societal expectations.

Source: ILO (2018), UN Women (2021), OECD (2024), and Ilyana Syafiqa Mukhriz Mudaris, Hafiz Hafizi Suhaimi, and Hawati Abdul Hamid (2024)

The theoretical understanding of care work has evolved over time, leading to the development of different frameworks that capture its multifaceted nature. Scholars have explored various dimensions of care work, particularly in how it intersects with the economy, labour market, and interpersonal relationships. Two prominent frameworks emerge in the literature, each offering a distinct perspective. First, the reproductive labour framework, rooted in Marxist theory, emphasises the economic contribution of unpaid care to both paid care and the non-care sector[10].

Second, the nurturance framework focuses on the relational aspect of care, distinguishing between nurturant (direct, face-to-face) or non-nurturant (indirect) care work[11]. Given these theoretical foundations, this paper conceptualise care work as the provision of physical and emotional support by both paid and unpaid caregivers[12].

Despite this evolving understanding, care work remains a relatively new field of study from an economic perspective with no clear consensus on what "care workers" encompasses. For instance, the ILO and the Organisation for Economic Co-operation and Development (OECD) define care workers broadly, including both direct and indirect care roles across health, education, and social work sectors[13]. This broad classification encompasses a wide range of roles, from teachers and nurses, to support functions like janitorial and clerical roles, all grouped under the same "care worker" umbrella.

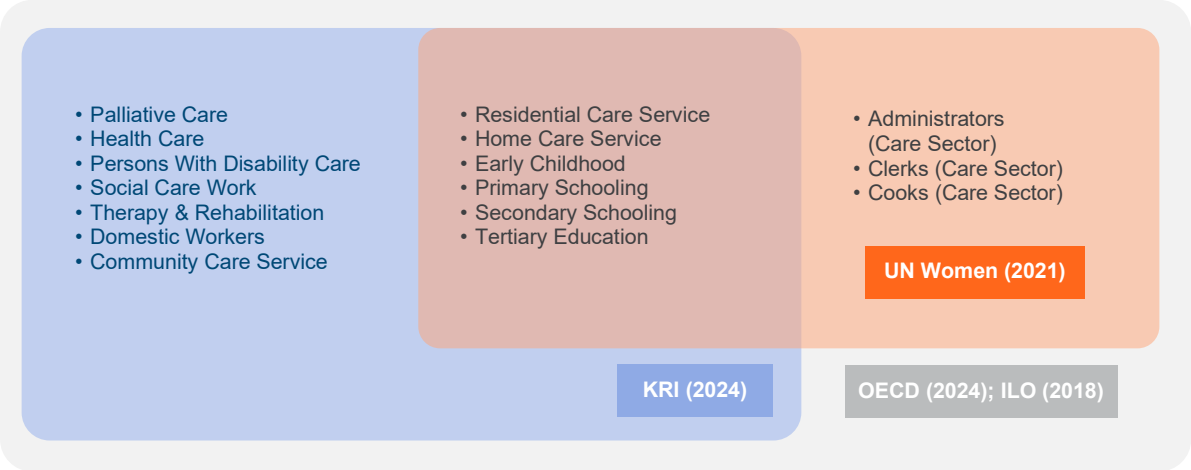
[10] Duffy (2005)
[11] Ibid.
[12] ILO (2018)
[13] Ibid.

However, some argue that such a broad range of workers may complicate analyses and may obscure the distinct needs and challenges faced by different workers[14]. In contrast, UN Women offers a more focused working definition, narrowing the scope to specific portions of the health and education sectors, particularly those related to intergenerational care, such as long-term care and early childhood care.

A further distinction commonly made in research is between formal[15] and informal[16] care work. However, this dichotomy has been criticised for its susceptibility to subjective interpretation and for overlooking the non-compensatory nature of much domestic care work[17]. Feminist literature has drawn attention to the value of unpaid care, particularly performed by women within the household, and argues that unpaid domestic work is as significant as paid labour outside the home[18].

This study focuses on direct care, which involves hands-on assistance provided by carers who interact directly with care recipients, particularly infants and children, PWDs, and the elderly. It does not include discussions of indirect care, such as the roles of cleaners in a hospital or account managers in early childhood centres, in order to provide a more focused analysis. Additionally, we adopt a functional definition of care work that encompasses work done in the realms of health, education, and social work. Figure 1.1 illustrates the workers included in our study compared to those referenced in relevant literature.

Figure 1.2: Functional definition of care worker



[14] Cruz et al. (2023)

[15] In formal settings, caregivers are paid care workers who are trained to provide care services in a professional capacity and/or are employed in a registered care centre. Examples include nurses, early childhood educators, and social workers. Source: Ilyana Syafiqa Mukhriz Mudaris, Hafiz Hafizi Suhaimi, and Hawati Abdul Hamid (2024)

[16] 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. Source: Ilyana Syafiqa Mukhriz Mudaris, Hafiz Hafizi Suhaimi, and Hawati Abdul Hamid (2024)

[17] Cruz et al. (2023)

[18] Ungerson (1995)

2. Demographics and Characteristics of Care Workers

In this section, we examine the profiles of unpaid caregivers and paid care workers in Malaysia to gain insights into the demographics of those involved in care work. Such insights are useful in identifying the challenges faced by different subgroups of care providers, enabling the design of more targeted interventions and support systems. Additionally, a deeper understanding of these characteristics is key to improving the well-being of care workers, enhancing care services, and ensuring that policy responses adequately reflect the realities of the care economy.

2.1. Unpaid caregivers

We begin by analysing the sociodemographic characteristics of unpaid caregivers to identify the groups most likely to assume caregiving responsibilities and the social and economic implications they face. These insights can help inform more targeted policies to better support caregivers.

Globally, there are about 2.0 billion people who perform care work on a full-time basis (defined as more than 40 hours per week) without receiving any pay[19]. The number is possibly even bigger if we were to include those who perform informal care while performing other paid jobs.

In 2023, about 7.0 million people in Malaysia were outside the labour market, and 43.9% of them cited family responsibilities as the main reason they opted out[20]. Besides that, it is also estimated that 5.1% of Malaysian adults[21] provide informal care[22], which will possibly increase in the future due to ageing phenomena, increased chronic and degenerative diseases, and also an increasing number of road and workplace accidents[23]. The proportion is probably bigger if we were to include other types of unpaid caregivers, such as mothers and homemakers.

However, the nature of unpaid care work— typically provided by family members, close relatives, and friends without financial compensation—makes it challenging to obtain a comprehensive picture of this segment. As a result, we primarily draw insights from studies available in the literature to gain a broad yet reliable understanding of caregivers in this category. The limitation of these studies is that not all groups of care recipients are covered extensively, particularly children and PWDs. Thus, the observations made may not unveil the whole picture of unpaid caregivers. However, they at least provide some insights that could be used as an adequate basis for understanding them.

[19] ILO (2018)
[20] DOSM (2024)
[21] National Institutes of Health (2019)
[22] According to the National Institutes of Health, informal care is the provision of unpaid care or support to others who need help due to long-term health conditions, to the elderly, or to people who were unable to care for themselves due to disability. The care provided includes personal care, healthcare, and other assistance such as financial support, supervision, and food preparation. Source: National Institutes of Health (2019)
[23] Siti Hajar Abu Bakar et al. (2014)

Demography

The findings presented in this section are drawn from an analysis of approximately 14 studies conducted between 2013 and 2024. These studies cover a wide range of localities, representing nearly all states in Malaysia. Most of the research focuses on informal caregivers for the elderly and those with critical illnesses, though a few studies also include caregivers for PWDs and children. While these limitations may challenge the representativeness of the data, they provide a sufficient overview of the nature and key characteristics of informal caregiving in Malaysia. Table 2.1 provides a summary of the studies.

Table 2.1: Summary of past studies on unpaid caregivers' characteristics in Malaysia

Author(s)	Year	Number of respondents	Type of care recipient	Locality
Erwan Ershad Ahmad Khan et al.	2024	250	Stroke patients	Kelantan
Aniawanis Makhtar et al.	2023	231	Elderly	Kelantan
Chan et al.	2023	17,286	Elderly, disabled adults, children & disabled children	Malaysia
Munusamy	2023	23	HIV patients	Kuala Lumpur, Selangor, Kedah & Perak
Wan Mohd Aiman Wan Ab Rahman and Mazlina Mazlan	2023	54	Stroke patients	Selangor
Nor Shahrina Mohd Zawawi et al.	2023	263	Stroke patients	Malaysia
Munirah A Taufik et al.	2023	92	Elderly	Selangor
Zuzana Aman et al.	2020	385	Elderly	Selangor
Zati Sabrina Ahmad Zubaidi et al.	2020	249	People with serious illness (palliative care)	Selangor
Tan et al.	2020	128	Stroke patients	Kuala Lumpur
National Institutes of Health	2019	730	Elderly	Malaysia
Suriawati Ghazali et al.	2015	166	Elderly with chronic illness	Selangor
Siti Hajar Abu Bakar et al.	2014	175	Elderly, PWDs & children	Kuala Lumpur & Selangor
Goh et al.	2013	56	Elderly	Kuala Lumpur & Selangor

These studies have established specific inclusion and exclusion criteria to qualify unpaid caregivers. These criteria are essential to ensure that the findings are representative of the situation of most caregivers. The inclusion criteria encompasses individuals who provide direct care, are not being paid for the care provided, are aged more than 18, and can read or write in English or Bahasa Melayu. Meanwhile, the exclusion criteria eliminate paid caregivers, family caregivers of institutionalised care recipients, and caregivers experiencing mental challenges or emotional distress.

Insights derived from the literature review observing informal care in Malaysia indicate several prominent characteristics of unpaid caregivers in the country, which can be summarised as below:

1. **The majority of unpaid caregivers are women.** This finding is consistent across all studies except for one that focuses on care for HIV patients, where men account for 60.0% of caregivers. In the other studies, the proportion of women among unpaid caregivers ranges from approximately 60.0% to 70.0%. This trend aligns with global patterns, where women constitute about 76.2% of the total unpaid caregiving population[24].

2. **Many of them are over 45 years old** although some studies also report that the respondents are primarily from the 25 – 44 age group. While the proportion varies among the studies, it is significant to note that most unpaid caregivers are older. Additionally, the majority of caregivers are married, a finding consistent across all studies except for one[25], which found that over 70.0% of its respondents were single.

3. **Caregivers are generally married and live together with care recipients.** More than 60.0% of the respondents involved as unpaid caregivers are married. Some studies also indicate that nearly 80.0% of caregivers live with the care recipients. Interestingly, not all caregivers are spouses; despite being married and residing with the recipients, many caregivers are actually children or children-in-law of the care recipients. This type of relationship accounts for more than 55.0% of the studies. Furthermore, the proportion of other caregivers, including siblings, relatives, maids, neighbours, and friends, is relatively small, at about 5.0% or less.

4. **They typically attained education at the secondary level and are not engaged in paid work.** In terms of education level, most studies indicate that about one in two caregivers has completed secondary education. However, it is also important to note that some studies report a high proportion of tertiary-educated caregivers, with over 60.0% of respondents in each study falling into this category. When comparing the types of occupations held by caregivers to their education levels, it is observed that studies featuring a higher percentage of tertiary-educated caregivers also show high proportions of those working, either full- or part-time. This suggests that many unpaid caregivers are balancing work responsibilities while caring for family members. However, most caregivers are reported as not working, which includes those who are unemployed, retired, or housewives. The observation aligns with global findings indicating that unpaid caregivers are often affected personally, socially, and financially due to their care responsibilities[26].

[24] ILO (2018)
[25] Munirah A Taufik et al. (2023)
[26] ILO (2018)

5. **Unpaid caregivers likely belong to households with low monthly income[27].** When it comes to household income, the proportion of those with incomes less than RM1,000 per month is quite staggering, accounting for more than 40.0% of the total respondents in some studies. The high number of unpaid caregivers among low-income families may indicate their limited access to care options, especially for the elderly and children. Additionally, another significant income group consists of those earning between RM1,000 and RM5,000. These families are often getting benefits from caregivers who are also working, either full- or part-time.

Time spent on caregiving

One significant characteristic of unpaid caregivers is the long hours they spend providing care to family members. When measuring this involvement, two dimensions should be considered which includes the number of years they have been providing care and the duration of their daily caregiving activities:

1. **Becoming a caregiver is a long-term commitment.** The studies show that more than 70.0% of unpaid caregivers have been providing care to recipients for at least two years. A study[28] also notes that over 48.0% of respondents have more than five years of caregiving experience, with 29.0% having provided care for more than 10 years. This is possibly due to the nature of the long-term care that they provide to the elderly. Besides that, some care recipients also have chronic diseases that need intensive care.

2. **Long hours are spent on caregiving.** In terms of daily caregiving, the proportion of unpaid caregivers who provide care for more than 10 hours a day is significantly high, exceeding 50.0%. This is particularly true for caregivers living together with their care recipients. The types of care that they provide may also include direct and indirect care. Care recipients with chronic diseases sometimes require assistance for longer since they are not able to fulfill their daily needs by themselves.

Understanding unpaid caregivers requires an evaluation of the varying levels of support and training they receive. Many caregivers receive support and assistance, particularly from family members[29], as well as from medical professionals who provide healthcare support. However, some studies indicate that there are caregivers who do not receive financial aid or welfare assistance[30]. Additionally, a significant number of caregivers lack care-related training[31], with over 70.0% reporting no formal education in caregiving. Those who do receive training are more likely to obtain healthcare support from practitioners[32]. This highlights the disparities in resources and training that caregivers encounter, which contribute to their diverse challenges. See Box 1 for further details on the challenges faced by unpaid caregivers.

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[27] National Institutes of Health (2019)

[28] Aniawanis Makhtar et al. (2023)

[29] National Institutes of Health (2019), Suriawati Ghazali et al. (2015) and Munirah A Taufik et al. (2023)

[30] Munusamy (2023) and Wan Mohd Aiman Wan Ab Rahman and Mazlina Mazlan (2024)

[31] See Aniawanis Makhtar et al. (2023), National Institutes of Health (2019), Tan et al. (2020) and Erwan Ershad Ahmad Khan, Wan Nor Arifin, and Kamarul Imran Musa (2024)

[32] Tan et al. (2020)

Box 1: Challenges faced by unpaid caregivers

There is a high proportion of unpaid caregivers in Malaysia, possibly due to the increased demand for care, especially for the elderly and children. The lack of a long-term care system for elderly care, combined with limited access to childcare and disabled persons care, has contributed to the rise of informal and unpaid care[33]. Most care-related work is preferred to be handled by family members or those who live together in the same household. Even though some caregivers work, either full—or part-time, they are still required to perform care-related duties. Consequently, unpaid caregivers face various challenges and difficulties, especially if they lack adequate support and assistance in delivering care-related tasks.

The burden of unpaid caregivers can be assessed through several key dimensions: physical and emotional health, economic costs, and personal and social impacts.

There are many contributing factors to the burden of caregivers. Among these are current employment status, the functional dependency level of care recipients, and the average hours of caregiving per day. Caregivers who are also working tend to experience a higher burden compared to unemployed caregivers. Additionally, long hours of caregiving and the presence of highly dependent care recipients further increase the burden on caregivers. Another factor influencing caregiver burden is the education level of caregivers; those with lower education levels tend to face a higher care burden. This is possible because caregivers with higher education levels are generally better equipped to cope with caregiving responsibilities and perceive caregiving as meaningful and satisfying, compared to those with lower education levels[34].

Furthermore, Malaysia still lacks comprehensive policies that address the needs of unpaid caregivers. The concerns and well-being of unpaid caregivers were initially acknowledged in the Community Welfare Policy 1990 and the Community Care Policy, followed by the National Social Policy 2003. However, the coverage of unpaid caregivers in these policies has been minimal.

Hence, unpaid caregivers require more than just support from family members and the community. Many caregivers prefer community support in the form of home-based assistance, nursing services, transportation, and support group services[35].

[33] Ilyana Syafiqa Mukhriz Mudaris, Hafiz Hafizi Suhaimi, and Hawati Abdul Hamid (2024)
[34] Zuzana Aman et al. (2020)
[35] Goh et al. (2013)

2.2. Paid care workers

We then turn our focus to paid care workers, examining their distribution across economic sectors and their demographic characteristics. This is followed by an analysis of their salaries and wages to assess earning patterns and levels across different care sectors. Lastly, we explore the presence of care workers within the informal sector to better understand their employment conditions.

Despite receiving monetary compensation for their work, paid care workers face multiple issues including low wages, poor working conditions, and limited career progression opportunities. However, this does not apply across all job categories within the care sector. Health and medical-related subsectors typically offer better employment conditions, while social care work and residential care are more often associated with lower-paying roles.

As mentioned earlier in Section 1, care workers fall within three broad categories namely education, health, and social work. According to the Malaysia Standard Industrial Classification (MSIC) 2008 codes, care-related subsectors are categorised under Section P (Education) and Section Q (Human Health and Social Work Activities). Table 2.2 outlines the subdivisions within each section and their respective groupings. While the education sector consists of a single division, the human health and social work activities sector is divided into three: human health activities, residential care activities, and social work without accommodation.

However, the context of social work in MSIC 2008 is perceived as having slight differences with definitions by the International Federation of Social Workers (IFSW) and the Malaysian Association of Social Workers (MASW). Both organisations emphasise that social workers are professionals who are well-trained and equipped with qualifications to provide service in addressing life challenges and enhancing well-being.

The definition of social work profession from IFSW is as follows:

> *"**Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people.** Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels." (*IFSW, 2024)

Meanwhile, the definition of social work by MASW is as follows:

> *"**Social work is a profession guided by a body of knowledge, values and skills, utilizing a bio-psycho-social approach, to facilitate optimal social functioning of individuals, families, groups and communities.** Social workers uphold a code of ethics and conduct based on the values of human rights and social justice. The profession also contributes towards social development and social change through the enhancement of social policies, legislation, programmes and services, appropriate to the needs of Malaysia's diverse socio-cultural population for a better quality of life." (*MASW, n.d)

Thus, the following discussion on paid care workers will use the term social care work since it is based on the context provided by MSIC 2008, a framework also used by DOSM to categorise the subsectors.

Table 2.2: Summary of Divisions and Groups under Section P & Q in MSIC 2008

SECTION	DIVISION	GROUP
P (Education)	Education	Pre-primary and primary education
		Secondary education
		Higher education
		Other education
		Educational support activities
Q (Human Health & Social Work Activities)	Human health activities	Hospital activities
		Medical & dental practice activities
		Other human health activities
	Residential care activities	Residential nursing care
		Residential care for mental retardation, mental health, and substance abuse
		Residential care for the elderly and disabled
		Other residential care activities
	Social work without accommodation	Social Work activities without accommodation for the elderly and disabled
		Other social work activities without accommodation

Source: DOSM (n.d.)

Demography

In this section, we examine the demographics and characteristics of paid care workers for four broad categories namely *Education, Human Health*, *Residential Care*, and *Social Care Work* based on available data from DOSM's Labour Force Survey[36].

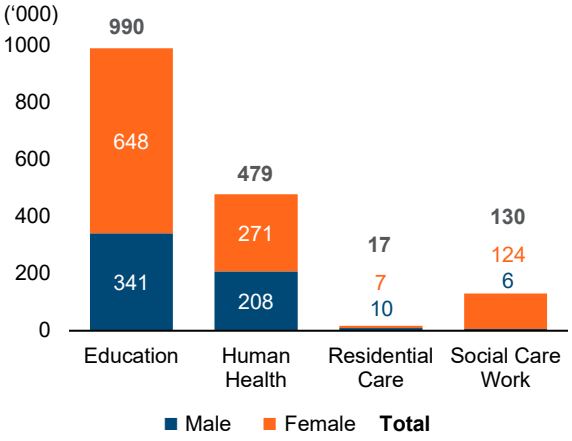
In 2023, there were approximately 1.6 million care workers in Malaysia[37], the highest number recorded to date. Based on the four subsectors categorised earlier, *Education* constitutes the largest portion, with 990,000 (61.2%) workers, followed by *Human Health* at 479,000 (29.6%), *Social Care Work* at 130,000 (8.1%), and *Residential Care* at 17,000 (1.1%) (Figure 2.1).

By gender, women comprise approximately 65.0% of total care workers. Delving further, the subsectors with the highest proportion of women are *Social Care Work* at 95.3%, followed by *Education* at 65.5%, *Human Health* at 56.5%, and *Residential Care* at 43.5% (Figure 2.2). Except for *Social Care Work*, all categories exhibit a more balanced gender distribution. Given that *Social Care Work* is a female-dominated subsector, it presents an interesting area for further observation, as gender disparity may lead to gaps in various areas, especially in pay and career advancement.

[36] It is important to note that data for some categories may not be available, and when available, high Relative Standard Error (RSE) may affect reliability. Hence, due to this limitation, caution should be applied when interpreting the findings.

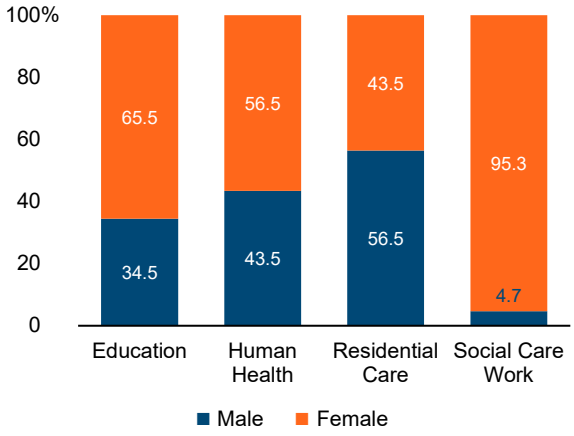
[37] DOSM (2023b)

Figure 2.1: Number of care workers, by subsector and gender, 2023



Source: DOSM (2023b)

Figure 2.2: Breakdown of care workers, by subsector and gender, 2023



Source: DOSM (2023b)

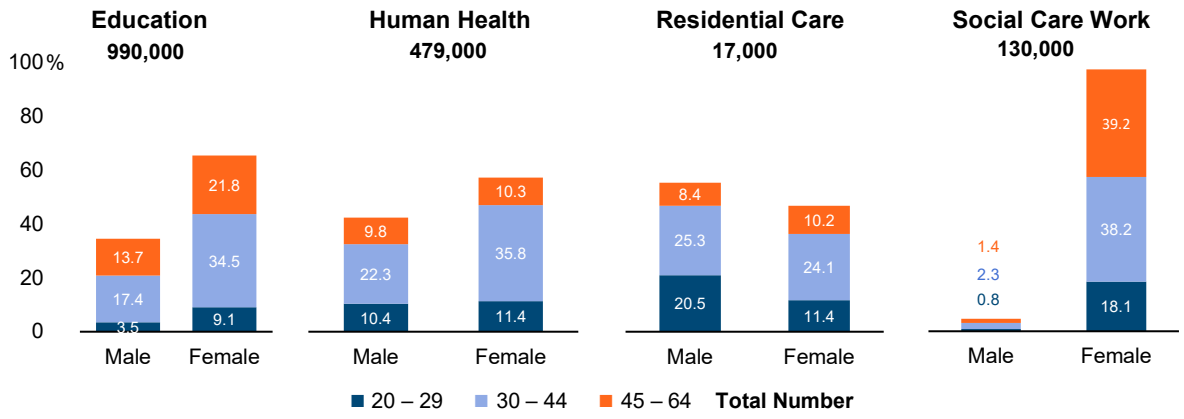
In Figure 2.3, we can see the breakdown of care workers by age group and gender. In the 20 – 29 age group, women have higher shares in all care subsectors except *Residential Care*, where the share of men aged 20 – 29 is relatively high at about 20.5% of the subsector workforce. Meanwhile, in the other subsectors, the share of men is slightly lower than that of women. Men aged 20 – 29 make up only 0.8% of the male workforce in *Social Care Work*, which is significantly lower compared to the 18.1% among women in the same age group.

Similar observations can be made for the 30 – 44 age group. Women generally have higher representation across all care subsectors except *Residential Care*, where the shares for both genders are nearly the same at around 25.0%. The low presence of men in this age group is most pronounced in *Social Care Work* at only 2.2% compared to 38.2% among women.

In the 45 – 64 age group, women also have higher shares than men in Education and Social Care Work, while the gender distribution is nearly equal for Residential Care and Human Health, at around 10.0%.

Overall, women's presence is more pronounced in care subsectors across most age groups, with notable exceptions in *Residential Care*, where gender distribution is more balanced, and *Social Care Work*, where men are significantly underrepresented, especially in the younger age groups.

Figure 2.3: Breakdown of care workers according to age group, by subsectors and gender, 2023



Source: DOSM (2023b)

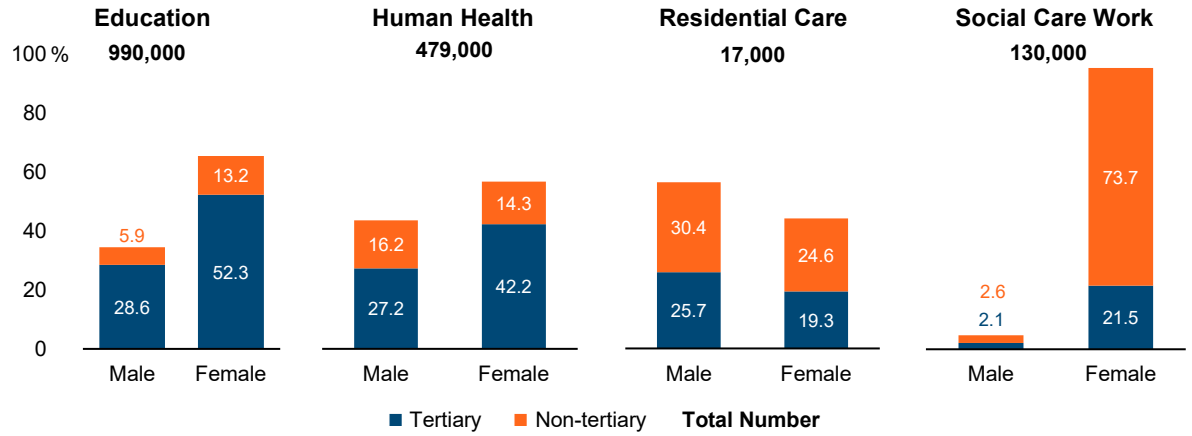
The level of education attainment varies in all care subsectors. More than half of the workers in *Education* and *Human Health* are tertiary educated. In the *Education* subsector, the share of tertiary-educated workers is 80.9%, followed by *Human Health* at 69.4%, *Residential Care* at 45.0%, and *Social Care Work* at 23.7%.

This shows that the *Education* and *Human Health* subsectors employ a higher proportion of tertiary-educated workers, while the *Social Care Work* subsector employs more non-tertiary-educated workers. In *Residential Care*, the distribution between tertiary- and non-tertiary-educated workers is nearly balanced, with non-tertiary-educated workers comprising 55.0%. The differences in educational attainment across subsectors are likely influenced by specific regulatory frameworks, qualification requirements, and varying levels of investment by the public and private sectors, particularly in the *Education* and *Human Health* subsectors.

Delving further into tertiary-educated care workers, Figure 2.4 shows that the share of women with tertiary education is significantly higher than that of men in the *Education*, *Human Health*, and *Social Care Work* subsectors. Specifically, women make up 52.3% compared to 28.6% in *Education*, 42.2% compared to 27.2% in *Human Health*, and 21.5% compared to 2.1% in *Social Care Work*. In contrast, in *Residential Care*, the share of men with tertiary education is higher compared to women, at 25.7% compared to 19.3%.

Among non-tertiary-educated workers, the share of women in the *Social Care Work* subsector is particularly significant, at 73.7%, compared to other subsectors. Besides that, men without tertiary education have a slightly higher share than women in *Human Health* and *Residential Care*, at 16.2% and 30.4%, respectively. This observation reflects earlier findings that men in these two subsectors are employed in semi-skilled and low-skilled jobs that require lower education qualifications.

Figure 2.4: Breakdown of care workers according to education attainment, by subsectors and gender, 2023



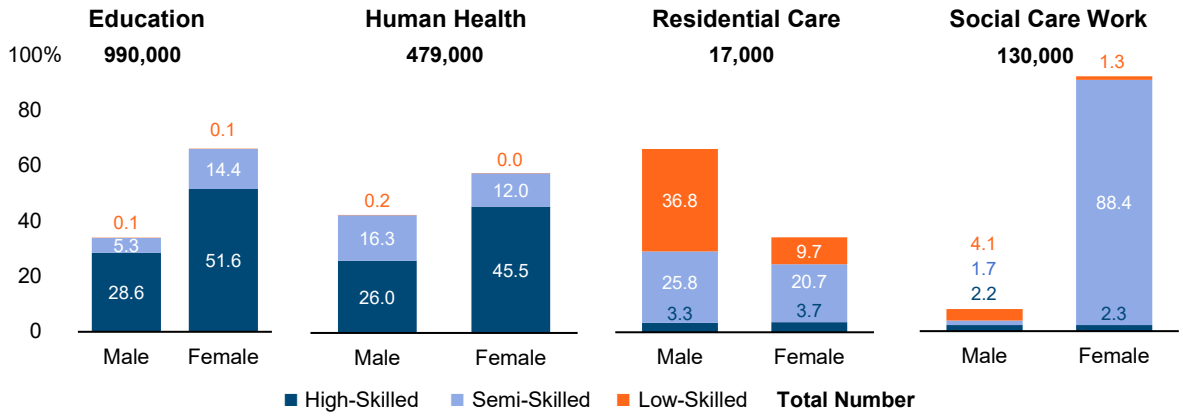
Source: DOSM (2023b)

In terms of skill level, the *Education* and *Human Health* subsectors employ high-skilled workers. The share of high-skilled workers in *Education* is 80.1%, while in the *Human Health* subsector, it is 71.5%. *Social Care Work*, on the other hand, is predominantly comprised of semi-skilled workers, accounting for about 90.1%. Meanwhile, the *Residential Care* subsector shows a balanced distribution of between semi- and low-skilled workers, each at about 46.5%. Notably, *Social Care Work*, previously identified as a female-dominated subsector earlier, is primarily filled with semi-skilled workers. Besides that, the *Residential Care* subsector presents significant findings, as it consists of both semi-skilled and low-skilled workers.

Figure 2.5 illustrates the dominant skill level for each care subsector, as previously explained. In terms of gender, high-skilled women workers dominate the *Education* and *Human Health* subsectors, comprising approximately 51.6% and 45.5% of the workforce, respectively. Similarly, in the *Social Care Work* subsector, semi-skilled women workers represent the largest proportion at 88.4%. Men, regardless of skill level, are featured much less in these four care subsectors. However, in *Residential Care,* men predominantly fill low-skilled positions, accounting for about 36.8% of the workforce in this area.

These observations clearly indicate that women dominate high-skilled roles in *Education* and *Human Health* and semi-skilled positions in *Social Care Work*. Meanwhile, men's dominance is more pronounced in *Residential Care*, particularly in low-skilled roles.

Figure 2.5: Breakdown of care workers according to skill level, by subsector and gender, 2023



Source: DOSM (2023b)

In summary, this subsection reveals that care workers in Malaysia are predominantly employed in the *Education* subsector, followed by *Human Health*, *Social Care Work*, and *Residential Care*. Women make up the majority in *Social Care Work*, *Education*, and *Human Health*, while men are slightly more prevalent in *Residential Care*. Care workers in Malaysia are relatively young, with the majority in the 30 – 44 age group; however, the *Social Care Work* subsector exhibits a balanced distribution of workers in both the 30 – 44 and 45 – 64 age groups. Most workers in the *Education* and *Human Health* subsectors have tertiary education, while *Residential Care* has an almost equal share of workers with tertiary and non-tertiary education. Conversely, only one in four workers in *Social Care Work* have tertiary education. In terms of skill level, high-skilled workers represent a significant share in the *Education* and *Human Health* subsectors, whereas *Social Care Work* has a larger proportion of semi-skilled workers, while the *Residential Care* subsector shows a balanced distribution between semi-skilled and low-skilled workers.

Salaries and Wages

This subsection examines the salaries and wages of care workers in Malaysia, highlighting critical disparities that impact certain care subsectors' ability to attract talent and enhance their professional standing. The literature indicates that care workers receive lower wages compared to those in other industries like construction or manufacturing whilst requiring similar levels of skill and training[38]. Furthermore, the pay gap within the care sector itself is also significant. For instance in OECD countries, pre-primary teachers receive a lower salary by 78.0% of the average salary for teachers. Besides that, care workers in India also receive a stipend, instead of a salary, for their services[39]. Addressing this issue is critical in enhancing the professionalism of the industry and attracting better talent. However, several factors contribute to the lower pay for care workers, including the gender gap, social norms, and limited opportunities for career advancement[40].

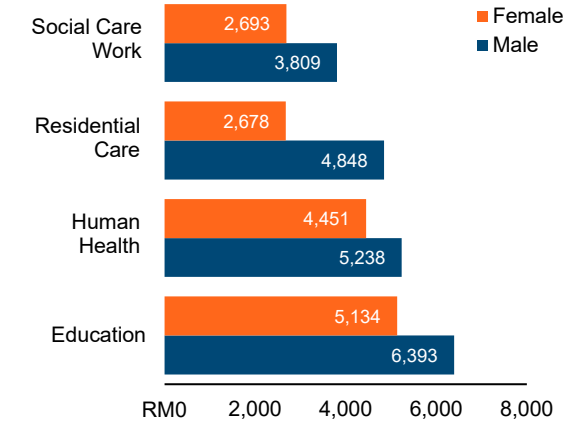
For this subsection, we will examine the differences in salary levels of care workers across the same four care subsectors, using data from DOSM's Salary and Wages Survey[41]. The analysis will cover multiple dimensions, including the pay gap between subsectors, gender, age group, education attainment, and skill level. The workers in the *Education* and *Human Health* subsectors received higher salaries than those in *Residential Care* and *Social Care Work*. This is possibly due to the higher education attainment required and the number of skilled jobs available in the subsectors.

Figure 2.6 shows that men earn higher pay than women across all care subsectors. The *Education* subsector offers the highest mean salaries and wages, with men earning RM6,393 and women earning RM5,134. This is followed by *Human Health*, where the mean salary is RM5,238 for men and RM4,451 for women. In *Residential Care*, the mean pay is RM4,848 for men and RM2,678 for women. For *Social Care Work*, men earn a mean salary of RM3,809, while women earn RM2,693. In terms of percentage, the largest pay gap between men and women is in the *Residential Care* subsector, at 44.8%, followed by *Social Care Work* at 29.3%, *Education* at 19.7%, and *Human Health* at 14.8%. Despite already having the lowest pay among the care subsectors, women in *Residential Care* and *Social Care Work* also face significant pay disparities compared to their male counterparts. These figures highlight the persistent gender-based wage inequalities within the care sector, particularly in subsectors with lower pay scales.

[38] ILO (2022)
[39] ILO (2018)
[40] ILO (2022)
[41] It is important to note that data for some categories may not be available, and when available, high Relative Standard Error (RSE) may affect reliability. Hence, due to this limitation, caution should be applied when interpreting the findings.

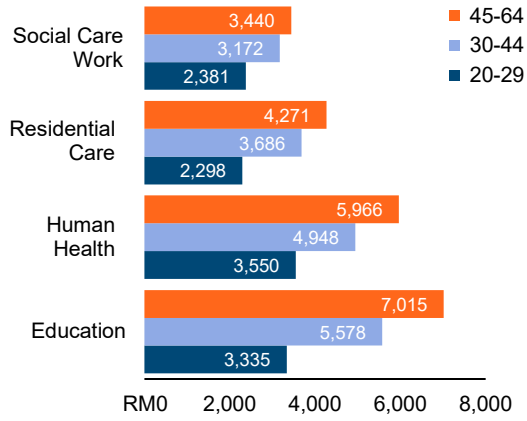
In terms of age group, as shown in Figure 2.7, the trends in mean salaries and wages are quite similar for all care subsectors. Workers aged 20 – 29 earn the lowest pay, followed by those aged 30 – 44 and 45 – 64. This indicates that older workers generally receive higher pay, which is expected as they progress in their careers. However, when comparing workers of similar ages across different subsectors, the 45 – 64 age group exhibits the widest pay gap, with a difference of 103.9% between the highest and lowest salaries. The 30 – 44 age group has a pay gap of approximately 75.9%, while the gap for the 20 – 29 age group is 40.1%. Generally, older care workers receive higher compensation compared to their younger counterparts; however, significant pay disparities still exist between subsectors.

Figure 2.6: Mean monthly salaries and wages of care workers, by subsector and gender, 2022



Source: DOSM (2022b)

Figure 2.7: Mean monthly salaries and wages for care workers, by subsectors and age group, 2022



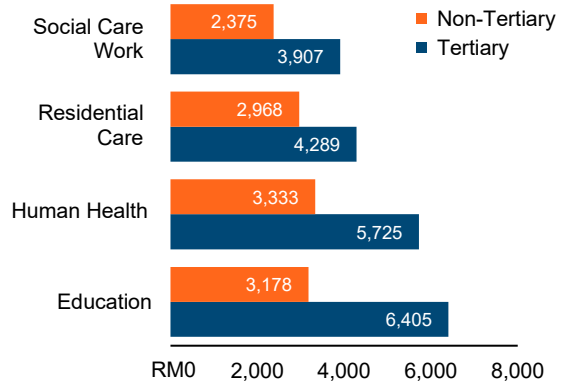
Source: DOSM (2022b)

In terms of education attainment, as shown in Figure 2.8, workers with tertiary education earn higher salaries than those without, reflecting the labour market expectation that tertiary-educated individuals have better job prospects and earning potential. In addition, there is a huge gap among tertiary-educated workers across subsectors. Those who have tertiary education and work in the *Education* subsectors get the highest pay, while those who are in *Social Care Work* receive the lowest. The education premium that workers in *Residential Care* and *Social Care Work* receive is not as high compared to those in *Education* and *Human Health*. The overall pay difference for tertiary-educated workers between the highest pay (*Education*) and the lowest pay (*Social Care Work*) is 63.9%, while for non-tertiary-educated workers, it stands at 33.8%. If we were to look at the pay difference between tertiary- and non-tertiary-educated by subsectors, *Education* shows the highest pay difference, at 101.5%. This is followed by the *Human Health* subsector with a pay gap of 71.8%, *Social Care Work* at 64.5%, and *Residential Care* at 44.5%.

As expected, Figure 2.9 shows that high-skilled workers receive the highest salaries compared to workers from other skill levels, highlighting the strong correlation between skill level and earning potential in the labour market. The *Education* subsector offers the highest pay for high-skilled workers, followed by *Human Health*, *Residential Care*, and *Social Care Work*. Hence, it is interesting to note that those in low-skilled jobs in the *Education* subsector can earn more than those who work in semi-skilled roles in *Social Care Work* and *Residential Care*.

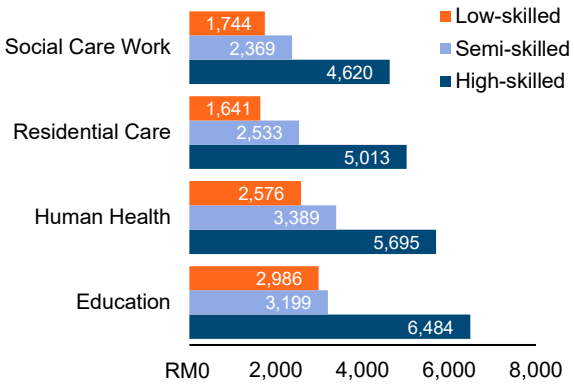
In this context, the pay gap between the lowest and highest mean salaries for low-skilled workers is the most significant, at 71.2%, while the pay gap for semi-skilled workers is 35.0%, and for high-skilled workers, it is 40.3%. When examining the subsectors, it is noteworthy that *Residential Care* has the highest pay gap between high-skilled and low-skilled workers, with the gap exceeding twofold. *Social Care Work* follows with a pay gap of 164.9%, while *Human Health* and *Education* have gaps of 121.1% and 117.1%, respectively.

Figure 2.8: Mean monthly salaries and wages of care workers, by subsectors and education attainment, 2022



Source: DOSM (2022b)

Figure 2.9: Mean monthly salaries and wages of care workers, by skill level and subsector, 2022



Source: DOSM (2022b)

To summarise, this subsection examines the pay gap across various dimensions, including gender, age group, educational attainment, and skill level. Our findings indicate that men earn higher salaries across all care subsectors. Across the subsectors, *Education* offers the highest pay, followed by *Human Health*, *Residential Care*, and *Social Care Work*. Notably, when comparing the gender pay gap across subsectors, *Residential Care* shows the largest disparity. Additionally, we observe that younger workers earn less than their older counterparts, although older workers experience the highest pay gaps across subsectors. In terms of educational attainment, the pay gap for individuals with tertiary education between subsectors is greater than for those without. Besides that, low-skilled care workers face significant pay gaps between subsectors compared to their semi-skilled and high-skilled counterparts.

Care workers in the informal sector

We move next to the care workers in the informal sector. Three key terms in the literature[42] are relevant to this discussion namely: the informal sector[43], informal employment[44], and informal economy[45]. Workers working in unregistered firms are known as informal sector workers. Meanwhile, workers in informal employment are those employed by firms that do not provide adequate labour protections despite the firms being formally registered. Together, these two groups form what is known as the informal economy. Those who work in the informal economy are vulnerable as the working arrangements often provide lesser job security, lower wage growth, limited career progression, and inadequate social protection[46].

In this subsection, the dataset from DOSM's Informal Sector and Employment Survey is used to analyse the conditions of the informal sector and employment, specifically for care-related subsectors in Malaysia. It is important to note that there is a lack of data on the informal sector within the *Residential Care* subsector since the sector is relatively small. Thus, this subsection will exclude that subsector from discussion. Instead, we will focus on the three remaining care subsectors: *Education*, *Human Health*, and *Social Care Work*.

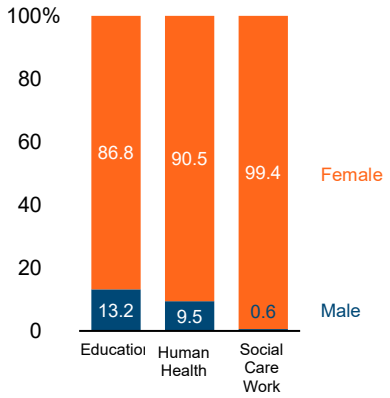
In 2021, there were about 72,000 workers in the informal sector for care-related subsectors in Malaysia. Overall, women make up 96.1% of the total workers, which is about 70,000 workers. The subsector with the highest number of informal workers is *Social Care Work*, with 50,500, followed by *Human Health*, with 11,600, and *Education*, with 10,600. Figure 2.10 shows the percentage of care workers in the informal sector for care-related subsectors by gender. In *Social Care Work*, about 99.4% of the workers are women, while in Human Health, 90.5% are women, and 86.8% are in *Education*.

In terms of age groups, as shown in Figure 2.11, the majority of workers in all care subsectors are aged 45 – 64, making up more than 67.0%. The highest proportion of this age group is found in the *Human Health* subsector at 77.7%, followed by *Social Care Work* at 66.8% and *Education* at 58.9%. The second largest group consists of workers aged 30 – 44, with shares of 26.3% in *Education*, 19.6% in *Human Health*, and 21.6% in *Social Care Work*. Workers aged 20 – 29 represent the smallest share across all care subsectors, with none exceeding 15.0%.

When examining educational attainment in Figure 2.12, it is noteworthy that the *Education* subsector has a higher proportion of tertiary-educated workers at 54.7%, compared to non-tertiary-educated workers at 45.3%. In contrast, the *Human Health* and *Social Care Work* subsectors have a greater share of non-tertiary-educated workers. In *Human Health*, 67.2% of workers are non-tertiary-educated, while 32.8% have tertiary education. In the *Social Care Work* subsector, the proportion of workers without tertiary education is significantly high at 90.7%, compared to just 9.3% who hold tertiary qualifications.

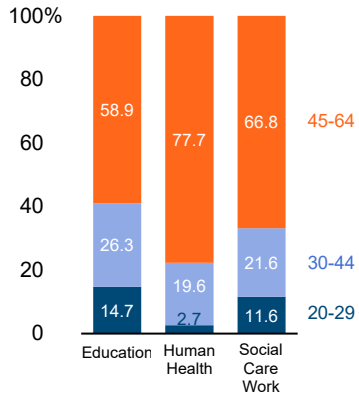
[42] Ab Razak Othman et al. (2020)
[43] Chen (2012)
[44] ILO (2013)
[45] Ibid.
[46] Ab Razak Othman et al. (2020), and Hawati Abdul Hamid and Nur Thuraya Sazali (2020)

Figure 2.10: Percentage of care workers in the informal sector, by subsector and gender, 2021



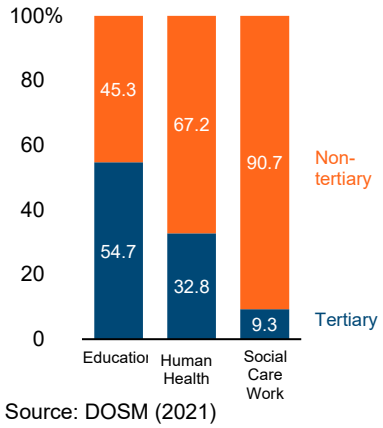
Source: DOSM (2021)

Figure 2.11: Percentage of care workers in the informal sector, by subsector and age group, 2021



Source: DOSM (2021)

Figure 2.12: Percentage of care workers in the informal sector, by subsector and education attainment, 2021



Source: DOSM (2021)

In this subsection, we find that women aged over 45 without tertiary education dominate the informal sector for all care subsectors. This has confirmed the findings in the literature that more women are participating in the informal sector due to barriers to formal employment, driven by entrenched gender roles and responsibilities at home. These societal expectations, combined with lower education and skill levels[47], as well as low household income, restrict women's ability to enter the formal sector[48]. As a result, they are more likely to join the informal economy, where work conditions are less regulated and social protections are inadequate. Although this trend is not specific to care-related sectors, the factors influencing women's participation in the informal sector are similar across all economic activities, including care. Moreover, the literature also highlights the participation of older women in the informal sector, with more than half of these workers being aged 40 and above. This trend is consistent across various sectors with studies showing that the informal sector becomes a crucial means of livelihood for older women, especially in contexts where there is a lack of age-friendly job policies and inadequate social safety nets and employment protections[49]. Nevertheless, data limitations for the informal sector and employment in care-related sectors also need to be addressed to gain better insights for policy interventions.

However, the *Education* subsector presents a slightly different picture, as a significant number of workers in the informal sector hold tertiary education. This happens possibly because many graduates are involved in educational activities, especially in early child education, regardless of whether the establishments that they work with are registered or not. Further analysis of graduate employability in the *Education* subsector should be made in order to understand this observation more deeply.

[47] Ab Razak Othman et al. (2020)
[48] Ramasamy (2017)
[49] Wan Ibrahim Wan Ahmad (2011)

3. Skills and Talent Development

Investing in the education and training of care workers is essential for improving service quality and ensuring the sustainability of the sector in meeting the growing demand for care. While skills development is critical for enhancing the quality of care and providing workers with better job prospects, it is equally important to recognise that issues of low pay and poor working conditions for certain types of care work cannot be solely attributed to the lack of professional certifications or skills.

Deep-rooted social biases often undervalue care work, necessitating broader policy interventions, such as public subsidies, increased minimum wages, and a wider decent work agenda, which will be explored in the next section. Training programmes are important in attracting new talent to the sector and enhancing the skills and job satisfaction of existing workers, but these improvements must be accompanied with efforts to address the systemic undervaluation of care work, ensuring fair pay and decent working conditions for all workers, regardless of professional certification.

In this section, we examine the education and training programmes already in place in Malaysia and help identify areas where more offerings are needed. The main dataset used for this section is the Graduate Tracer Study, a survey conducted by MOHE on graduates from local, public, and private higher education institutions (HEIs), and the National Training Index by HRD Corp.

3.1. Care courses offered by higher education institutions

We begin by examining the tertiary education sector[50], focusing on the availability of care-related programmes offered by Malaysia's HEIs. This involves assessing the range and depth of programmes available as education at a higher level is crucial in preparing individuals for careers in education, health, and welfare services. Following this, we will evaluate the impact of these programmes on talent generation, focusing on how well they align with the evolving needs of the care industry and the extent to which they produce skilled talents.

[50] Tertiary or higher education refers to all formal post-secondary level education. In the Malaysian context, a person with a tertiary or higher education qualification refers to those who have completed schooling at the secondary level and whose highest level of education is above Form 5 (usually 18 years and above) under the national curriculum.

In 2023, about 5,548 programmes were offered by Malaysian HEIs across all sectors[51], study levels[52] and study fields[53]. Of these, 856 programmes, or 15.4% of the total, are care-related studies across ten major fields of study. According to MOHE's study fields classification, these fall under *Education* with 377 programmes (6.8%) and *Health & Welfare* with 479 programmes (8.6%).

Since these two classifications are still broad, we further divide them into five sub-fields to examine the distribution of the type of programmes and the number of graduate outputs. Table 3.1 shows examples of programmes for each sub-field.

Table 3.1: Sub-study fields in care-related programmes

SUB-FIELDS	EXAMPLES OF PROGRAMME
School and Higher Education	Education science, teaching and training, training for teachers with subject specialisation, educational leadership & management, curriculum and pedagogy, etc.
Early Child Care and Education	Early childhood education, preschool education, etc.
Medical and Dentistry	Medicine, dentistry, psychiatry, obstetrics & gynaecology, surgery, anesthesiology, pharmaceutical, etc.
Allied Health	Health science, nursing, midwifery, therapy, rehabilitation, dietetics, radiotherapy, nutrition, diagnostic and imaging, etc.
Social and Welfare	Social work, social & family counselling, family care services, social admin, correctional science, etc.

Source: Authors' classification

The landscape of care-related education displayed notable differences in the availability of programmes and the number of graduates across the five subfields (Figures 3.1 and 3.2).

[51] In 2020, these include 20 public universities and 140 TVET institutions (comprising polytechnics, community colleges, and other public training institutes), as well as 435 private institutions (comprising 51 private universities, 10 private foreign universities with local campuses, 38 private university colleges, and 336 private colleges).

[52] Three levels of study are: (1) Post-graduates: PhD, master, post-grad diploma/cert, professional (2) Graduates: bachelor, advanced diploma/certificate, and (3) Pre-bachelor: diploma, certificate, etc.

[53] Eight major fields of studies are: education; arts & humanities; social sciences, business & law; science, mathematics & computers; engineering, manufacturing & construction; agriculture & veterinary; health & welfare and services & others.

Figure 3.1 highlights the number of care-related programmes by study level, showcasing the variety of educational pathways within the care sector. *School & Higher Education* emerges as the most prominent, with a total of 335 programmes. This field is well-represented across diploma, bachelor's, and postgraduate levels, offering approximately 130 diploma and 155 bachelor's programmes. In comparison, *Medicine & Dentistry* and *Allied Health* are also robustly supported, though to a lesser extent, with a total of 211 and 220 courses respectively. These fields maintain a strong mix of diploma, bachelor's, and postgraduate offerings, with *School & Higher Education* particularly thriving at the bachelor's level. *Allied Health* closely follows with 220 courses, reflecting the growing demand for education in this sector.

In contrast, *Social & Welfare* and *Early Child Care & Education* present a different scenario. With only 90 programmes in total, this field lags behind the others, especially in postgraduate options, which are entirely absent. The diploma and bachelor's levels are relatively balanced, with 46 and 44 programs, respectively. Nevertheless, overall, *Early Child Care & Education* remains the least represented in terms of available educational opportunities.

The other chart in Figure 3.1 shifts the focus to how these educational programmes translate into the number of graduates across the fields. The trends in growth and demand become even clearer. *Early Child Care & Education*, with its extensive range of programmes, also produces a substantial number of graduates in 2023— 6,553 in total. Most of these graduates come from diploma and bachelor's programmes, with around 3,300 diploma graduates and 2,600 bachelor's graduates, while postgraduate programs contribute approximately 650 graduates.

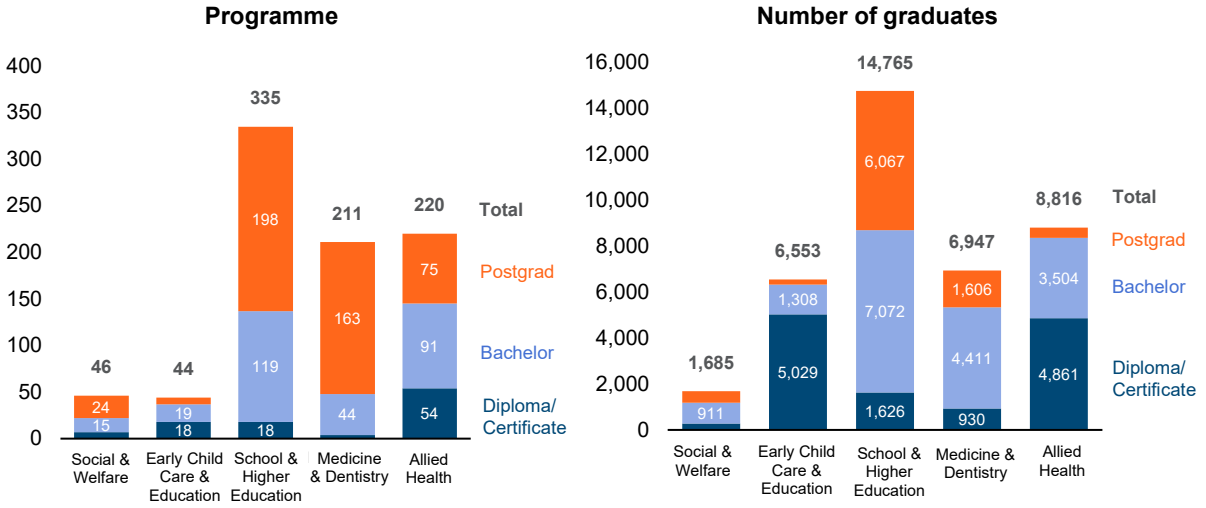
The standout, however, is *School & Higher Education*, which produces 14,765 graduates. This field offers a broad range of programmes and generates a large number of diploma and bachelor's graduates, making up the majority of the total. The postgraduate level is also strong, with 2,700 graduates, indicating continued growth across all educational stages.

Meanwhile, *Medicine & Dentistry* and *Allied Health* continue to assert their importance, with 6,947 and 8,816 graduates, respectively. Both fields show a well-distributed number of graduates across diploma, bachelor's, and postgraduate levels, reflecting the steady demand for professionals in health-related sectors.

Finally, *Social & Welfare*, much like in the previous figure, remains the smallest field, producing just 1,885 graduates, primarily from diploma programmes. While modest in numbers, these graduates still reflect the vital role of social welfare in society, even if on a smaller scale.

Overall, these figures highlight the growth and diversity within care-related education, with fields like *Early Child Care & Education* and *School and Higher Education* leading the way. At the same time, they emphasise the need for further investment and development in areas like *Social & Welfare* to create a more balanced and comprehensive care education system for the future.

Figure 3.1: Number of care courses and graduates, by study level, 2023



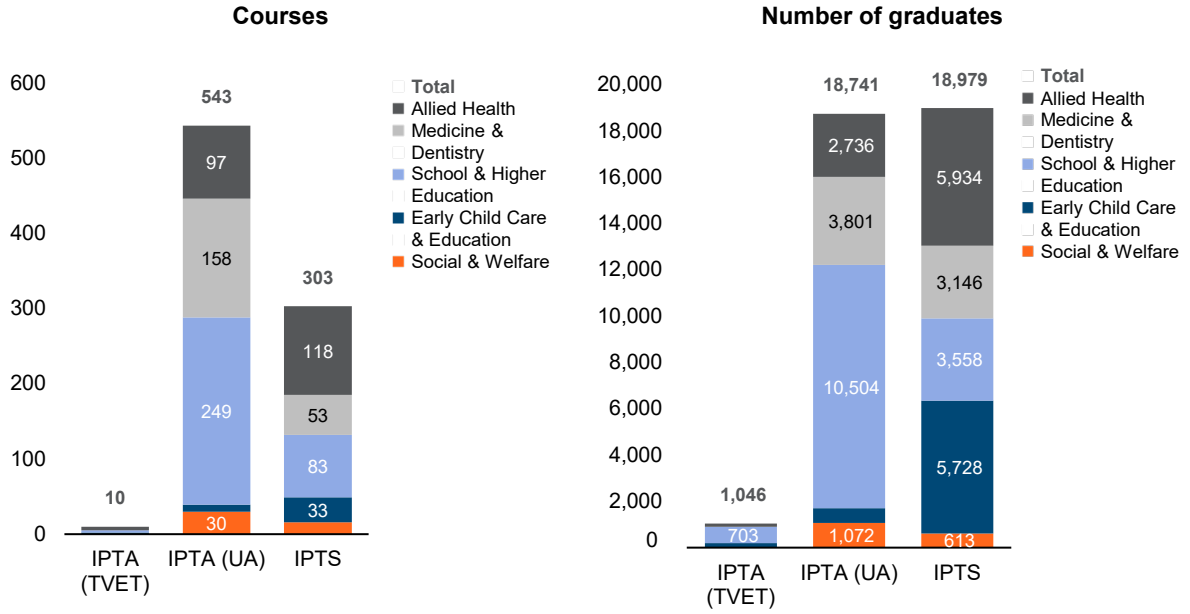
Source: MOHE (2023)

Source: MOHE (2023)

In terms of course providers, the chart below sheds light on the availability of courses and the number of graduates in this crucial sector classified by institution type, specifically focusing on three categories:

- **IPTA (UA)**: *Institusi Pengajian Tinggi Awam (Universiti Awam)* or Public Higher Education Institutions/Public University,
- **IPTA (TVET)**: *Institusi Pengajian Tinggi Awam (Teknikal dan Vokasional)* or Public Higher Education Institutions (Technical and Vocational)
- **IPTS**: *Institusi Pengajian Tinggi Swasta* or Private Higher Education Institutions

Figure 3.2: Number of care courses and graduates, by institution type, 2023



Source: MOHE (2023)

Source: MOHE (2023)

Figure 3.2 shows the number of care-related programmes offered by the three categories of institutions. A striking difference emerges as we observe the vast range of courses provided by public universities, or IPTA (UA), which dominate the landscape with 543 programmes, which make up 63.4% of the total.

These universities offer a diverse range of programmes, particularly concentrating in fields such as *Allied Health*, *School & Higher Education*, and *Medicine & Dentistry*. This data clearly shows that public universities are at the forefront of care education in Malaysia, providing numerous pathways for students seeking to enter these vital sectors.

Meanwhile, the private institutions, or IPTS, offer 303 care-related programmes. While they may not offer as many courses as their public counterparts, private institutions still play a pivotal role in the care education ecosystem. Their programmes are particularly strong in fields like *Allied Health*, *Early Child Care & Education*, and *School & Higher Education*, where the demand for professionals is steadily growing. Private institutions are filling a key gap in care education, complementing the efforts of public universities.

However, the scenario is quite different when it comes to IPTA (TVET) institutions, which specialise in technical and vocational education and training. With only 10 programmes on offer, these vocational institutions seem to occupy a much smaller niche within the care education system. Their limited range of programmes suggests a more focused approach, perhaps catering to specialised areas of care education that require technical skills. Nonetheless, their contribution, though small, is not insignificant.

The other chart in Figure 3.2 shifts the focus from programmes to graduates, giving us a clearer picture of how these institutions translate educational opportunities into workforce outcomes. Here, we find a more balanced scenario, where private and public institutions are producing almost equivalent numbers of graduates. IPTS slightly edges out public universities by producing 18,879 graduates in 2023. These graduates are largely concentrated in fields like *Allied Health*, *Early Child Care & Education*, and *School & Higher Education*, indicating that private institutions are significant contributors to the care workforce, producing a steady stream of talent to meet the growing demands of the sector.

However, IPTA (UA), are not far behind, with 18,741 graduates. While they offer more programmes than private institutions, their graduate output is almost equal, suggesting that public universities also play a critical role in providing care professionals. Graduates from public universities are heavily represented in fields such as *School & Higher Education*, *Early Child Care & Education*, and *Allied Health*, reflecting the institutions' broad reach and influence across the care sector.

Interestingly, IPTA (TVET) institutions, despite offering only 10 programmes, produced 1,046 graduates in 2023. This indicates that, while their offerings are limited, these vocational programmes are densely populated, perhaps catering to a more specialised workforce with specific technical skills. Their contribution, though smaller in scale, is nonetheless valuable, particularly in the more specialised sectors of care education.

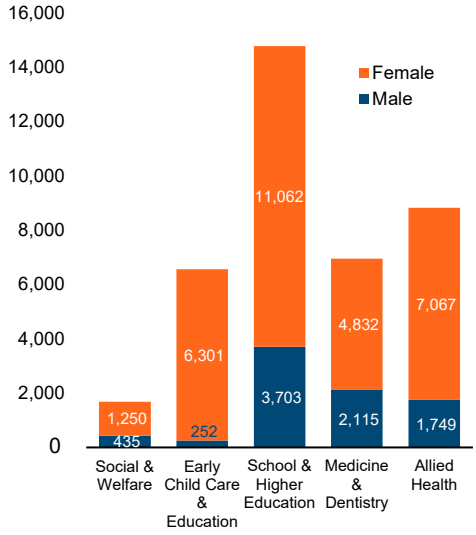
Together, the figures reveal a dynamic and multifaceted care education system. Public universities clearly lead the way in course offerings, while private institutions closely match them in terms of graduate output, demonstrating the vital role both sectors play in shaping the future care workforce. However, the story of vocational institutions is quite different.

Despite their potential, these institutions make only a small contribution, offering a limited number of programmes and producing relatively fewer graduates. While they may cater to specific and more technical areas of care, their scope is narrow and underdeveloped, indicating an untapped potential in this sector.

The modest output from vocational institutions highlights a pressing need for greater investment and expansion in these programmes. With the right support, vocational education could become a more significant player in addressing the increasing demand for skilled care professionals. This data emphasises the importance of not only strengthening existing public and private university programs but also enhancing the capacity of vocational institutions. Expanding their role would ensure a more diverse, well-rounded workforce that can meet the growing and complex needs of the care sector in the years to come.

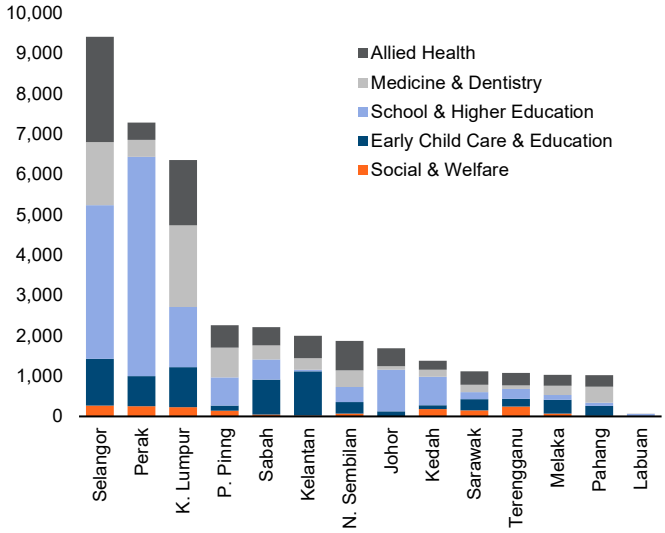
Figures 3.3 and 3.4 provide a glimpse into the gender distribution and geographical variations of care talents.

Figure 3.3: Number of graduates in care courses, by gender, 2023



Source: MOHE (2023)

Figure 3.4: Number of graduates in care courses, by state, 2023



Source: MOHE (2023)

In Figure 3.3 the story of gender imbalance across care-related fields emerges clearly. Certain fields, like *Social & Welfare* and *Early Child Care & Education*, are overwhelmingly female-dominated, with nearly 100% of the graduates being women. These fields, traditionally associated with caregiving roles, continue to reflect gendered occupational patterns, as men remain significantly underrepresented. The field of *School & Higher Education* follows a similar trend, though with a slightly higher proportion of male graduates compared to *Social & Welfare* and *Early Child Care & Education*. Still, women are the clear majority in this sector.

The fields of *Medicine & Dentistry* and *Allied Health* tell a different story, suggesting that the perception of care-related careers may be shifting. In *Medicine & Dentistry*, although women still outnumber men, the gender gap is narrower, indicating a more balanced representation.

This balance could reflect broader societal changes, as medical careers gain acceptance as viable paths for all genders. *Allied Health* stands out as the most gender-balanced field, with a significant presence of both male and female graduates. This indicates that the more specialised, technical roles in *Allied Health* attract a more diverse range of students, possibly due to the expanding opportunities and professional growth in this sector.

Moving on to Figure 3.4, the geographic distribution of care graduates highlights regional disparities in access to education and training, though it is important to note that these disparities may be influenced by the locations of educational institutions. Selangor, for instance, stands as the clear leader, producing over 9,000 graduates across all care-related fields, a reflection of the state's robust infrastructure and educational institutions. While geographical concentration is not necessarily a disadvantage—given that many students from various states may choose to study out of their home state and potentially return after graduation—it is worth noting that Selangor's significant output contributes substantially to the national care workforce. Other states, such as Penang, Perak, and Johor, also show strong outputs, with Penang's contributions in *Allied Health* and *Medicine & Dentistry* possibly due to the presence of specialised medical education centers in the region.

However, the data reveals that not all regions are equally represented. States like Kelantan, Terengganu, Melaka, and Negeri Sembilan have fewer graduates, reflecting a more limited range of care education programmes. At the far end of the spectrum, Labuan and Perlis produce the smallest number of graduates, likely due to their smaller populations and fewer educational institutions specialising in care-related fields. This uneven distribution raises important questions about how access to care education is structured and whether more needs to be done to expand these opportunities in less represented areas.

Taken together, these charts tell a story of both progress and challenges within Malaysia's care education landscape. While the presence of strong female representation in care-related fields reflects a continuing commitment to these essential professions, the notable absence of men in many sectors—especially *Social Welfare* and *Early Child Care & Education*—suggests a need to reconsider how these roles are perceived and promoted. Additionally, the stark regional differences in graduate output underscore the importance of addressing geographic disparities in educational access. Expanding care education programs in underserved regions could help create a more balanced, nationwide care workforce.

3.2. Training and certification programmes

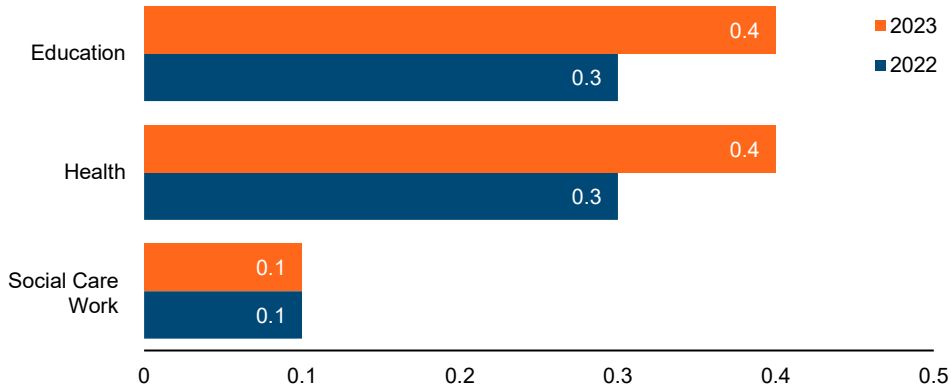
Hands-on skills and practical knowledge are crucial to ensure the delivery of high-quality care services. Training and certification courses play a vital role in developing competencies. In addition to formal education in care-related tertiary programmes, these courses further enhance care workers' capacity and capability to perform their jobs effectively. The skills acquired through such training may not only improve their proficiency but also enhance their skill levels and pay.

In this section, we examine the training capacity and efficacy of care-related courses by using the National Training Index (NTI) by HRD Corp[54]. First published in 2022, the NTI measures the level of training development capacity and commitment of employers in Malaysia. It also serves as an indicator to track progress and assess the impact of training and development on workforce skills and productivity. The index is measured across three dimensions and 18 indicators. However, the NTI has a limitation, the data only covers specific indicators as stated in the measurement.

Insights into training programme efficiency are valuable to explore, as they indicate the readiness and expertise that care workers possess to deliver quality care services. Therefore, we examine the care-related sector under the NTI to investigate the preparedness of the care industry in developing its workforce. The sector is categorised into three main subsectors, (1) *Health*, (2) *Education*, and (3) *Social Care Work*.

Figure 3.5 illustrates the training index score across three subsectors. The subsectors that fall under the *Health* category include residential nursing care, hospital activities, medical and dental practices, and other human health activities. The *Education* subsector encompasses pre-primary and primary education, secondary education, higher education, educational support activities, and other educational services. The *Social Care Work* subsector consists of social work activities without accommodation, residential care activities, other residential care activities, and additional social work activities without accommodation.

Figure 3.5: Training index score, by subsector, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

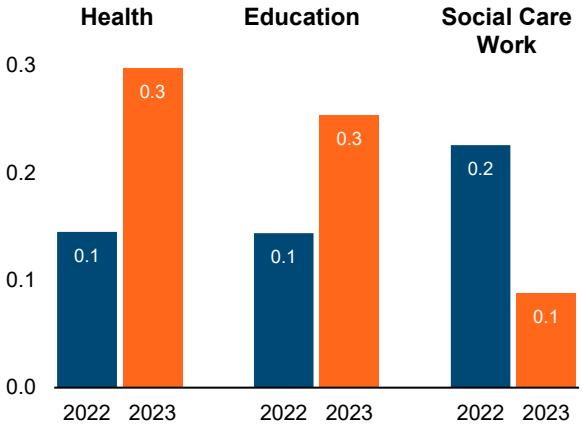
By the overall training index, all subsectors have increased their score in 2023 from 2022. The increase in training index scores across subsectors indicates more commitment from employers to provide training and improve the competency of their workers. The training index score for the *Education* subsector has increased from 0.3 in 2022 to 0.4 in 2023. Similarly, the index score for the Health subsector has increased from 0.3 in 2022 to 0.4 in 2023. However, these scores are far below the national index score which is at 0.75 in 2023.

[54] NTI covers training performance across all five main economic sectors, which include Manufacturing, Services, Mining & Quarrying, Construction, and Agriculture, Forestry & Fishing. The evaluation of the index scale of 0 to 1 are ranked into four categories namely Leader (0.76-1.0), Experienced (0.51 to 0.75), Adopter (0.26-0.50) and Beginner (0.00-0.25).

Both the *Education* and *Health* subsectors' scores are in the Adopter category, which is the classification that is set by HRD Corp. The category means that the firm or industry is moderately prepared and committed to training including having adequate training plans and allocations. In contrast, the index score for *Social Care Work* has not changed much over the period, remaining below 0.1 or in the Beginner category. This category means that there is low participation and commitment to training. These overall index scores reflect the firms' low readiness, commitment, and participation in increasing their workers' knowledge and competency.

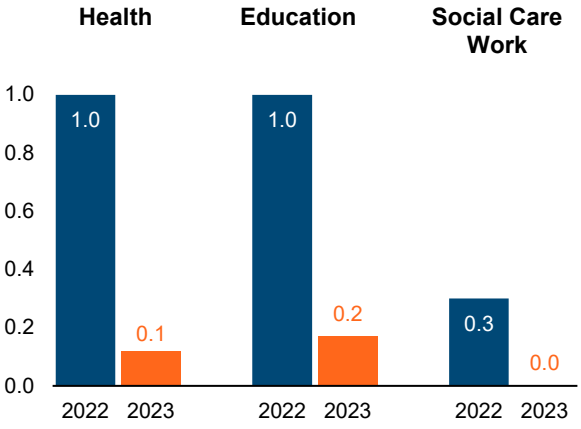
We then moved to the first dimension which is firm preparedness and training commitment[55], looking at the indicators that measure financial allocation for training per worker (Figure 3.6) and the availability of training facilities at the employer's premises (Figure 3.7).

Figure 3.6: Index score for financial allocation for training per worker, by subsector, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

Figure 3.7: Index score for availability of training facilities at own premise, by subsector, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

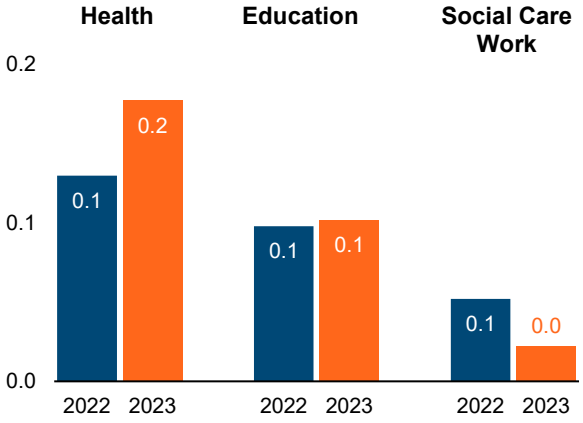
From the reports, we can see that all indicators in Firm Preparedness and Training Commitment for the subsectors increased from 2022 to 2023 except for the indicator that measures training budget allocation per worker (for *Social Care Work*) and training facilities availability (for all subsectors). The *Health* and *Education* subsectors showed an improvement in their readiness and commitment to training in 2023. Both subsectors scored higher points in getting their skilled workers trained and also having designated training units in their firms. In terms of training allocation per worker and number of employees trained, both subsectors are improving steadily over the period.

For the *Social Care Work* subsector, the scores that measure the utilisation rate of the HRD Corp levy and the number of employees trained are improving from below 0.1 in 2022 to 0.3 in 2023. However, in Figure 3.6, the indicator of training budget allocation per worker for *Social Care Work* decreased from 0.2 in 2022 to 0.1 in 2023, which means that firms have reduced their commitment to allocating a training budget per worker.

[55] Dimension 1 (Firm Preparedness and Training Commitment) is measured by seven indicators that include the amount of financial assistance allocated for training per worker; the utilisation rate of the HRD Corp levy; the number of employees trained; the number of skilled workers trained; enrolment in Recognition of Prior Learning (RPL); the availability of training facilities at the firm's own premises; and the availability of a designated training unit.

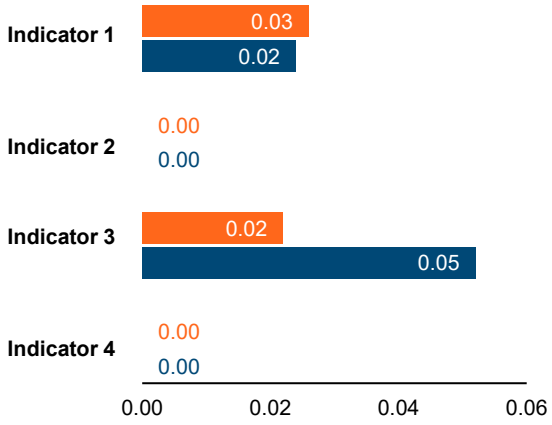
As for the indicator of training facilities availability, as shown in Figure 3.7, all subsectors experienced a decrease in the score index, where many firms have probably changed the usage of their training facilities on the premises to some other uses. This could be because many firms are outsourcing their training needs as part of cost-cutting measures or focusing more on on-the-job training. This may limit the internal training initiatives, especially hands-on practices and knowledge-sharing sessions among the workers. Compared to other subsectors, the *Social Care Work* firm's commitment to training is declining rapidly, and budget allocation and training facilities are not readily available to the workers. This will decrease competency and may lower the quality of the care-related services provided to their clients.

Figure 3.8: Index score for skilled workers who attended certification courses, by subsector, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

Figure 3.9: Index score for social care work subsector in Dimension 2 (skills development), by indicator, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

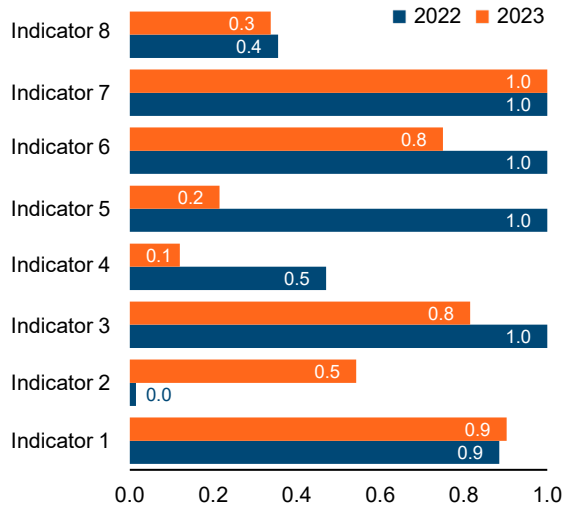
Next, we will examine the second dimension, skill development, which is assessed by four indicators: the number of training days attended, enrolment in technical courses, the number of skilled workers who attended certification courses, and enrolment in practical/hands-on training.

Similarly to the previous dimension, the *Health* and *Education* subsector are doing better in skill development, as compared to the *Social Care Work* subsector. We can see an increase in the indicator that measures the number of training days attended for the *Health* and *Education* subsectors. Besides that, the *Health* subsector's score also increases for the indicator that measures the number of skilled workers who attended courses for certification. There is also an increase in the *Education* subsector's score on enrolment in practical and hands-on training.

However, if we focus on the *Social Care Work* subsector in Figure 3.8 since it showed a reduction in the index score for skilled workers who attended certification courses, we can also observe insignificant scores for the other indicators. This may imply two possible scenarios, either there are not enough skilled workers in the *Social Care Work* subsectors, or there are no course certifications available in the market for social care workers.

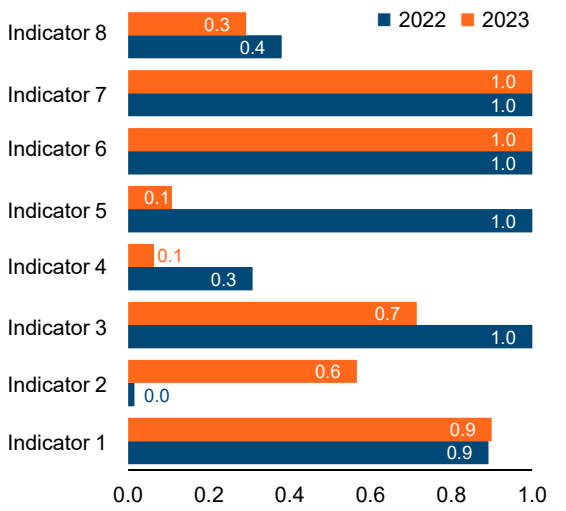
In addition, the *Social Care Work* subsector scored very low in three other indicators, including the number of training days attended, enrolment in technical courses, and enrolment in practical or hands-on training, as shown in Figure 3.9. This has put the *Social Care Work* subsector at risk of reduced competency among the workers and potentially lower service quality.

Figure 3.10: Index score of training provider effectiveness for Health subsector, by indicator, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

Figure 3.11: Index score of training provider effectiveness for Social Care Work subsector, by indicator, 2022 – 2023



Source: HRD Corp (2022) and HRD Corp (2023)

The third dimension, which is on training provider effectiveness, is measured by eight indicators that are enrolment in competent training providers; enrolment with certified trainer; enrolment in courses with regular content evaluation; enrolment in training provider for certification course; enrolment in digital training; enrolment in regular or repetitive training courses; enrolment in training provider with complete training facilities; and enrolment with established training providers.

In this dimension, the *Health* (Figure 3.10) and *Social Care Work* (Figure 3.11) subsector experienced decreases in multiple indicators. The *Health* subsector registers a reduction of score in the indicators that assess enrolment in courses with regular content evaluation, enrolment in training providers for certification courses, enrolment in digital training, enrolment in regular or repetitive training courses and enrolment with established training providers. Despite the critical content needed for the *Health* subsector in their training programs, the enrolment for courses that have regular content evaluation, courses for certification, and in digital learning mode is lesser as compared to the previous year. It shows that the training environment for the *Health* subsector is not conducive enough to provide better training content.

Meanwhile, the *Social Care Work* subsector has four indicators with reduced scores, which include enrolment in courses with regular content evaluation, enrolment in certification courses, enrolment in digital training, and enrolment with established training providers. However, *Social Care Work* is doing well for the indicators that measure enrolment in courses with competent training providers and certified trainers, courses that are held regularly, and courses with training provided with complete facilities.

Touching briefly on the *Education* subsector, there is a decrease in two indicators, which measure enrolment in digital training and enrolment in courses for certification. Compared with other subsectors, the *Education* subsector is still lacking in enrolment, with competent training providers and also enrolment in training providers that have complete training facilities. This means that the effectiveness of the training providers for the *Education* subsector needs to be improved further since it is still lacking in trainers' competency, training facilities and content coverage.

4. Care Job Market

In this section, we shift the focus from care workers to the broader care job market in Malaysia based on available data from DOSM's Employment Survey [56]. It delves into labour market trends in terms of job[57] creation and vacancies to understand the current conditions[58] and opportunities in this sector. The analysis helps identify emerging opportunities within the sector and potential areas where policy interventions can improve the quality and accessibility of care jobs. Additionally, reviewing care job opportunities is crucial for ensuring that the sector offers decent jobs with fair pay and career growth prospects.

Figure 4.1 provides an overview of available jobs in all care subsectors by skill level. In 2023, the total number of jobs was about 268,000, of which 133,000 were in *Education*, 117,000 were in *Human Health*, 2,000 were in *Residential Care*, and 16,000 were in *Social Care Work*. As shown in Figure 4.2, high-skilled jobs account for the largest proportions in the *Education* and *Human Health* subsectors, with 61.8% in *Education* and 54.1% in *Human Health*. The share of semi-skilled jobs is 28.9% in *Education* and 39.8% in *Human Health*. Low-skilled jobs make up less than 10.0% of the total in both subsectors.

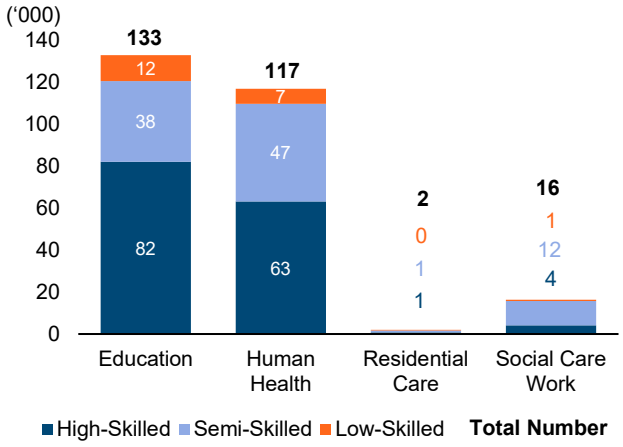
In contrast, semi-skilled jobs dominate the *Residential Care* and *Social Care Work* subsectors, with 49.6% in *Residential Care* and 71.0% in *Social Care Work*. Low-skilled jobs remain below 10.0% in all subsectors, except *Residential Care*, where they represent 13.7% of the total.

[56] The survey is implemented using an establishment approach, covering establishments in the categories of large, medium, small, and micro. Source: DOSM (2023a)

[57] Jobs refers to the total labour required by firms to produce goods & services, comprising of filled jobs and vacancies. Source: DOSM (2023a)

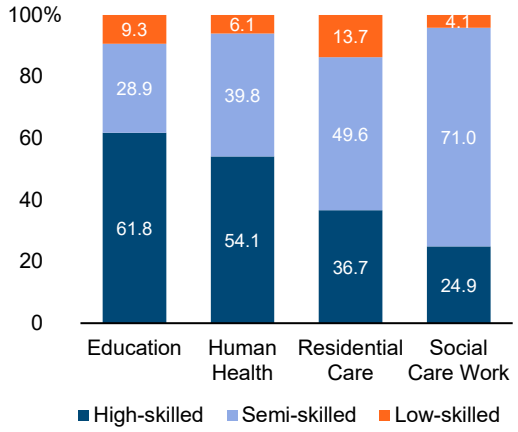
[58] It is important to note that data for some categories may not be available, and when available, high Relative Standard Error (RSE) may affect reliability. Hence, due to this limitation, caution should be applied when interpreting the findings.

Figure 4.1: Number of jobs, by subsector and skill level, 2023



Source: DOSM (2023a)

Figure 4.2: Breakdown of jobs, by subsector and skill level, 2023



Source: DOSM (2023a)

This indicates that the *Education* and *Human Health* subsectors offer jobs requiring higher qualifications and expertise, while *Residential Care* and *Social Care Work* provide more labour-intensive roles. These job characteristics shape perceptions of the nature and demands of care work and may also influence the work environment and pay levels for care workers.

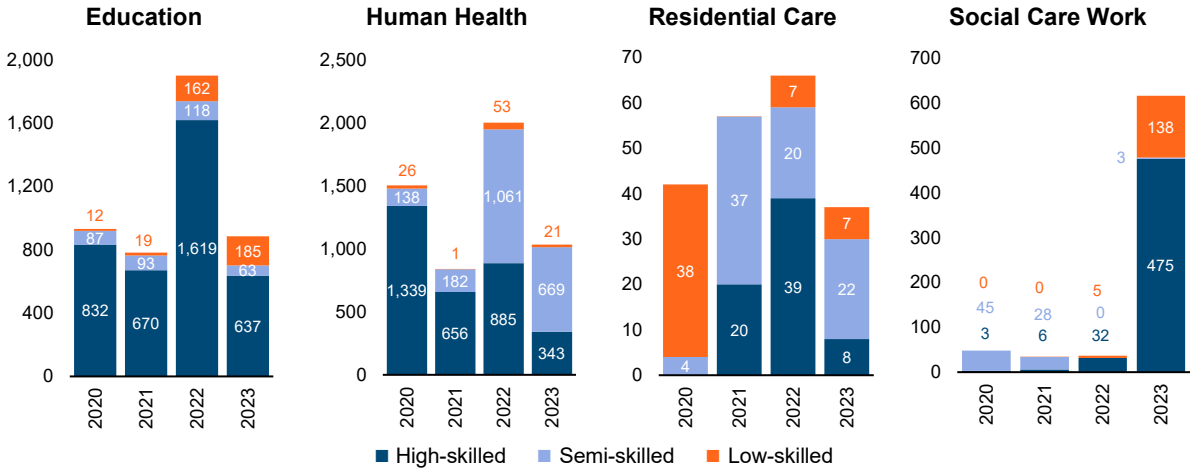
4.1. Job opportunities

Job creation and vacancies are two key indicators used to assess job opportunities in the care subsectors. These indicators can also reflect the demand and supply dynamics of care work. Job creation refers to newly generated positions, and vacancies refer to positions that have yet to be filled. The analysis in this subsection uses data between 2020 and 2023 to examine the trend and dynamics between job creation, vacancies, and filled positions.

Figure 4.3 shows the number of newly created jobs in care-related subsectors by skill level. In *Education*, the number of newly created high-skilled jobs fluctuates from 832 positions in 2020 to 637 positions in 2023, but with a spike of 1,619 positions in 2022. Meanwhile, the newly created semi-skilled jobs in *Education* are increasing steadily from 12 positions in 2020 to 185 positions in 2023. As for the *Human Health* subsector, the number of high-skilled jobs is decreasing from 1,339 new positions in 2020 to only 343 new positions in 2023. Conversely, the newly created semi-skilled jobs for *Human Health* are increasing from 138 positions in 2020 to 669 positions in 2023.

As for the *Residential Care* subsector, the number of newly created jobs is significantly small. However, we can observe that the number of new high-skilled jobs is decreasing from 20 positions in 2021 to 8 positions in 2023, while semi-skilled jobs are increasing from 4 new positions in 2020 to 22 new positions in 2023. Interestingly, there was a huge jump in newly created high-skilled jobs in the *Social Care Work* subsector from 3 positions in 2020 to 475 positions in 2023. A similar trend could also be seen for semi-skilled jobs, where the number of new jobs jumped from 45 new positions in 2020 to 138 positions in 2023.

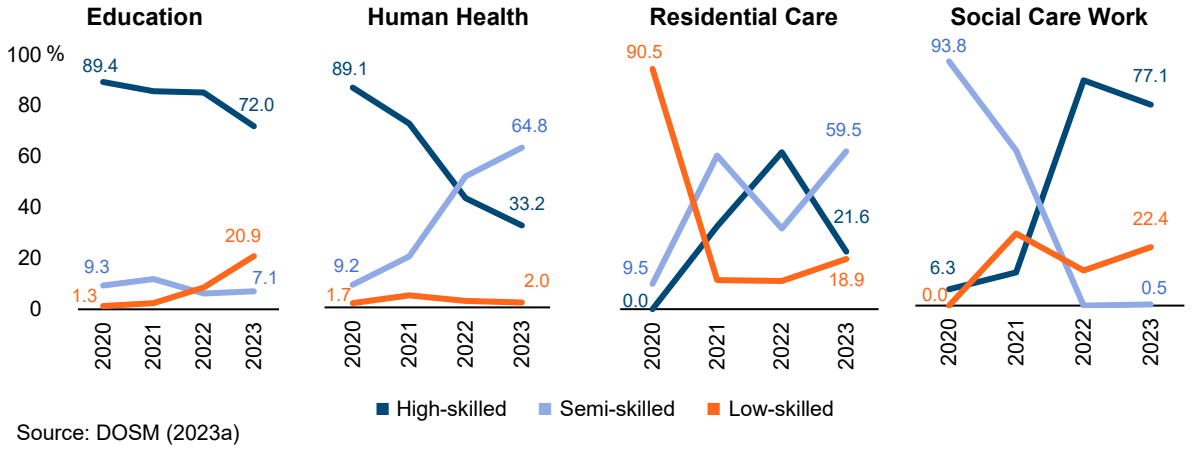
Figure 4.3: Number of newly created jobs for care subsectors, by skill level, 2020 – 2023



Source: DOSM (2023a)

Figure 4.4 shows the breakdown of newly created jobs in all care subsectors. The proportions of newly-created high-skilled jobs are decreasing in all subsectors. In *Education*, the majority of jobs created are for high-skilled positions. However, the trend for newly created high-skilled jobs is declining, from 89.4% in 2020 to 72.0% in 2023. A similar decline is observed for semi-skilled jobs, which decreased from 11.9% in 2021 to 7.1% in 2023. Conversely, the share of low-skilled jobs in the *Education* subsector has increased significantly, rising from 1.3% in 2020 to 20.9% in 2023.

Figure 4.4: Breakdown of newly created jobs for care subsectors, by skill level, 2020 – 2023



Source: DOSM (2023a)

In the *Human Health* subsector, the share of newly created high-skilled jobs is declining rapidly, dropping from 89.1% in 2020 to only 33.2% in 2023. This reduction is offset by an increase in the share of semi-skilled jobs, which rose from 9.2% in 2020 to 64.8% in 2023. Meanwhile, the share of newly created low-skilled jobs in this subsector has remained consistently low over the same period.

The share of new high-skilled jobs in the *Residential Care* subsector increased from almost none in 2020 to 59.1% in 2022. However, it then decreased to 21.6% in 2023. The share of semi-skilled jobs is also rising from 9.5% in 2020 to 59.5% in 2023. This significant increase in high- and semi-skilled jobs in the subsector is significantly reducing the share of newly created low-skilled jobs, from 90.5% in 2020 to only 18.9% in 2023.

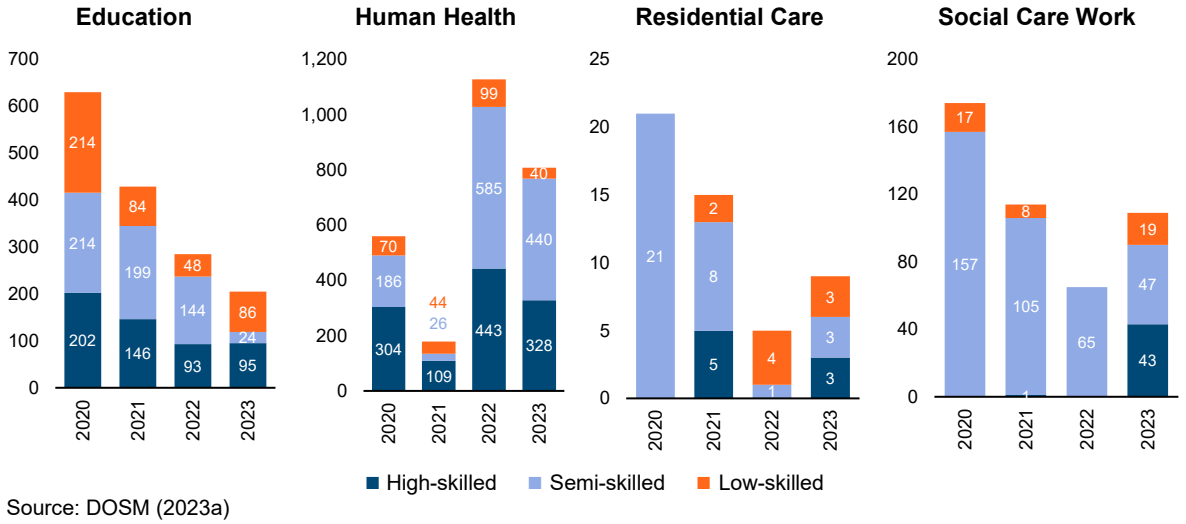
Interestingly, the share of high-skilled jobs in *Social Care Work* is increasing dramatically from 6.3% in 2020 to 77.1% in 2023. This shift coincides with a drastic decline in the creation of semi-skilled jobs within the subsector, falling from 93.8% in 2020 to a mere 0.5% in 2023. Meanwhile, the share of low-skilled jobs is increasing, rising from almost none in 2020 to 22.4% in 2023.

These findings indicate that many high-skilled jobs are being created in *Residential Care* and *Social Care Work*, in contrast to low-skilled jobs in *Residential Care* and semi-skilled jobs in *Social Care Work*. To provide context, our earlier discussion revealed that these two subsectors were predominantly composed of semi-skilled workers. Additionally, we observe that the trend for high-skilled jobs in *Education* and *Human Health* is decreasing, while the shares of newly created low-skilled jobs in *Education* and semi-skilled jobs in *Human Health* are on the rise.

Now, we move to job vacancies in care-related subsectors, as shown in Figure 4.5. Since 2020, the number of job vacancies in the *Education* subsector has been reducing at all skill levels. Vacancies for high-skilled jobs are decreasing from 202 in 2020 to 95 in 2023, and vice versa for semi-skilled vacancies, from 214 in 2020 to 24 in 2023, as well as for low-skilled jobs, from 214 in 2020 to 86 in 2023. The overall trend for the *Human Health* subsector is fluctuating, where the number of vacancies was reduced from 2020 to 2021 before it went up in 2022 and reduced again in 2023. There was a high jump in the number of semi-skilled job vacancies for the *Human Health* subsector, from 186 in 2020 to 440 in 2023. The number of vacancies for high-skilled jobs is also high but stagnant over the same period. Meanwhile, the vacancies for low-skilled jobs have been slightly declining from 70 in 2020 to 40 in 2023.

The number of job vacancies for *Residential Care* is very small. The number of job vacancies in this subsector decreased from 2020 to 2022 before it went up again in 2023. There is a significant fall in the number of semi-skilled job vacancies from 21 in 2020 to 3 in 2023. A similar overall trend for the number of job vacancies for the *Social Care Work* subsector has been observed. The number of semi-skilled job vacancies is also decreasing from 157 in 2020 to 47 in 2023. However, the number of high- and low-skilled job vacancies is increasing.

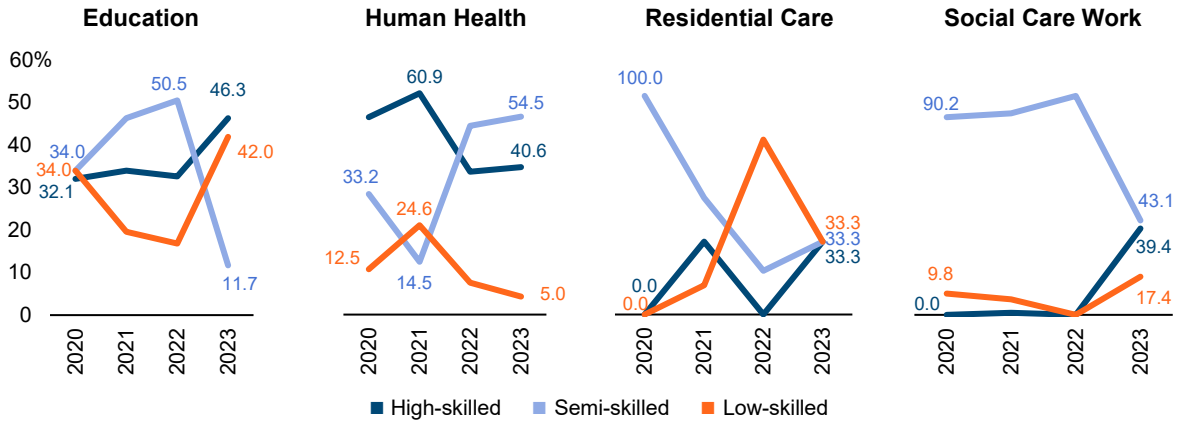
Figure 4.5: Number of vacancies for care subsectors, by skill level, 2020 – 2023



Source: DOSM (2023a)

In Figure 4.6, we can assess the market's capacity to fill care jobs by examining the vacancies present. For *Education*, vacancies for high-skilled jobs remained stagnant at over 30.0% from 2020 to 2022, before jumping to 46.3% in 2023. Despite a reduction in newly created high-skilled jobs, these vacancies remain difficult to be filled. Vacancies for semi-skilled jobs increased from 34.0% in 2020 to 50.5% in 2022 but then fell to 11.7% in 2023. Meanwhile, vacancies for low-skilled jobs decreased from 34.0% in 2020 to 16.8% in 2022, only to rise rapidly to 42.0% in 2023. This indicates that many workers entering the *Education* subsector are shifting from low-skilled to semi-skilled jobs.

Figure 4.6: Breakdown of vacancies for care subsectors, by skill level, 2020 – 2023



Source: DOSM (2023a)

In *Human Health*, the share of vacancies for high- and low-skilled jobs has decreased, particularly from 2021 onwards. The share of vacancies for high-skilled positions is falling from 60.9% in 2021 to 40.6% in 2023, while the share for low-skilled jobs is also decreasing from 24.6% in 2021 to 5.0% in 2023. During the same period, the share of semi-skilled job vacancies increased significantly, rising from 14.5% in 2021 to 54.5% in 2023. These trends correspond with the emergence of newly created jobs, indicating that the new semi-skilled positions in the *Human Health* subsector will take time to be filled. In contrast, the reduction in vacancies for high- and low-skilled jobs likely reflects the decline in newly created positions within the subsector.

The trend for high-skilled job vacancies in *Residential Care* has remained consistently low from 2020 to 2023. In contrast, semi-skilled job vacancies decreased significantly, falling from 100.0% in 2020 to almost none in 2022. Meanwhile, low-skilled job vacancies increased from nearly zero in 2020 to 80.0% in 2022, before declining to 33.3% in 2023. The change in percentages is substantial because the actual numbers are relatively low. Hence, when comparing the share of newly created jobs, it is evident that high- and semi-skilled positions in *Residential Care* are filled relatively easily. However, this is not the case for low-skilled jobs, which take longer to fill, possibly due to the physical demands required for the work.

In the *Social Care Work* subsector, semi-skilled job vacancies decreased from 90.2% in 2022 to 43.1% in 2023. During the same period, high- and low-skilled job vacancies increased. High-skilled job vacancies increased from nearly none in 2020 to 39.4% in 2023, while low-skilled job vacancies rose from 9.8% in 2020 to 17.4% in 2023. The increase in the share of high-skilled jobs is attributed to the growth in newly created positions.

Overall, this section highlights that the *Education* and *Human Health* subsectors are predominantly comprised of high-skilled jobs, whereas the *Residential Care* and *Social Care Work* subsectors primarily feature semi-skilled positions. In terms of job creation, a significant number of high-skilled jobs are being generated in the *Education* and *Social Care Work* subsectors, contributing to an increase in high-skilled job vacancies. Conversely, newly created semi-skilled jobs are outpacing the share of high-skilled positions in both the *Human Health* and *Residential Care* subsectors. Similar trends can also be observed in the rising semi-skilled job vacancies within these subsectors.

5. Decent Care Work

Care work, both paid and unpaid, is fundamental to societal functioning, enabling individuals to fully engage in the workforce while safeguarding the well-being of families and communities. Despite its critical importance, the care sector grapples with significant challenges, including low wages, insufficient recognition, and a lack of professionalism. Thus, it is crucial to integrate the decent work agenda into discussions about care work to guarantee that caregivers receive fair wages, recognition, and adequate support. This section will explore various initiatives at global and national levels aimed at improving decent work conditions in the care sector, highlighting how these efforts can foster economic growth and enhance social well-being.

The significance of care provision to economic growth cannot be overstated; it accounts for approximately 9.0% of global GDP and employs around 381 million workers, representing about 11.5% of total world employment[59]. Notably, women comprise roughly two-thirds of the global care workforce, underscoring the gendered nature of this field. Moreover, unpaid care work disproportionately impacts women, often hindering their ability to enter or thrive in the labour market, leading many to seek informal employment to balance caregiving responsibilities.

To address these challenges, government interventions are vital for facilitating women's re-entry into the labour market and reducing the reliance on unpaid care. Initiatives should aim to eliminate barriers faced by unpaid caregivers, ensuring access to appropriate care arrangements for their dependents. The pursuit of decent care work not only enhances the quality of care services but also improves the employment conditions for care workers, ultimately benefiting both caregivers and care recipients.

It is important to recognise that the quality of care services directly correlates with the conditions under which caregivers operate. While emotional attachment between caregivers and care recipients plays a significant role in providing quality care[60], the need for professionalisation and improvement in care work remains paramount.

The cost of care, often perceived as determined by demand, is more accurately influenced by the skills and conditions under which care is delivered. This highlights the necessity for a balanced approach: as care work is professionalised and improved, we must also ensure that access to affordable care remains available to prevent an increase in unpaid caregiving responsibilities.

[59] ILO (2018)
[60] Ibid.

The ILO has introduced the decent care work initiative that includes both paid and unpaid care work. This comprehensive approach is essential to improving the conditions of paid care work while simultaneously addressing the challenges faced by unpaid caregivers. The initiative focuses on three main areas: (1) recognising, reducing, and redistributing unpaid care work; (2) rewarding and creating decent work for paid care workers; and (3) ensuring fair representation for care workers in social dialogues and collective bargaining.

5.1. Recognise, reduce and redistribute unpaid care work

Recognising unpaid care work is critical for understanding its importance and impact. Given its relational and home-based nature, unpaid care work is often performed by family members who volunteer their time without any formal acknowledgment of their contributions. To address this, establishing mechanisms to quantify and record unpaid care work is essential for setting a baseline for evaluation and policy development.

In the Asia Pacific region, only a few developed countries, including Australia, Japan, South Korea, and New Zealand, incorporate time-use surveys into their national statistics systems regularly. Meanwhile, several developing countries have conducted similar surveys, but others, like Singapore, have never initiated any form of time-use assessment[61].

In Malaysia, although a small stand-alone time-use survey was conducted in 1990 and a larger one in 2003, there remains a lack of systematic data collection on time use, which limits understanding of unpaid care work[62]. The 2003 survey, which included more than 30,000 households and respondents aged 15 to 64, provided valuable insights. The results from this survey were instrumental in formulating the Action Plan for the Advancement of Women.

Global care provision faces two main challenges: addressing population growth and meeting commitments outlined in the Sustainable Development Goals (SDGs). These challenges necessitate significant improvements in care provision to meet the rising demand, particularly among the elderly and children. Government and private sector interventions are crucial to avoid increasing the number of unpaid caregivers due to limited access to paid care options.

In terms of redistributing unpaid care work, employment services must also cater to employees with caregiving responsibilities who balance formal work and care duties. Comprehensive and reliable care policies are essential for achieving favourable outcomes for employees who juggle both roles. Additionally, enhancing active labour market policies can help facilitate the transition of unpaid caregivers into formal employment.

Besides that, creating high-quality part-time work opportunities with flexible arrangements can assist unpaid caregivers in entering the labour market while earning stable income. However, the availability of such work is contingent on the overall market conditions. State intervention is required to promote high-value-added economic activities, which can stimulate the creation of quality jobs. Furthermore, ensuring social protection coverage for all types of employment, including informal and contract work, is vital.

[61] ILO & UNDP (2018)
[62] KRI (2019)

Redistributing unpaid care work between genders is another critical aspect of creating a more equitable care environment. Establishing gender-equal social norms can help balance caregiving responsibilities, which are often disproportionately assigned to women in Malaysia. To facilitate women's entry into the labour market, access to reliable and sustainable care options must be improved, as many working mothers still rely on family members for childcare[63].

5.2. Reward care workers with decent work

Despite their contributions, many paid care workers lack decent and stable careers within the care sector. The situation is more dire for unpaid care workers. Decent work encompasses fair pay, sustainable career progression, safe working conditions, and adequate recognition. Unfortunately, many paid care workers do not experience these benefits, primarily due to the informal nature of their employment.

To address this, it is critical to highlight that existing regulations governing informal and part-time work arrangements are often inadequate in ensuring job quality and worker protection. Current regulations may focus more on the operational standards of care centers rather than the rights and conditions of the care workers themselves. For instance, many informal and part-time care workers lack access to basic benefits such as paid leave, social protection, and job security. This gap can lead to inconsistent working conditions and lower job satisfaction among workers, undermining their overall well-being.

A shift in policy focus may be required, placing greater emphasis on regulating the conditions of informal and part-time work directly, ensuring that these workers receive adequate pay, job security, and access to essential benefits. Strengthening the legal framework and enforcing existing regulations can help elevate the quality of jobs in the care sector, making it a more attractive and sustainable career option. Without comprehensive regulations, the shift from informal to formal employment may rely solely on individual providers, undermining the sustainability of care work as a profession. Support for non-profit organisations delivering care services is also crucial in ensuring that employees receive the necessary benefits.

Skill development is another critical component of decent care work. Ensuring that care workers have the opportunity to acquire qualifications and certifications is essential for enhancing their expertise and the overall quality of care provided. The perception that paid care work requires only physical strength rather than technical skills must be challenged.

In Malaysia, initiatives by the Ministry of Women, Family and Community Development (KPWKM), in collaboration with organizations like the Malaysia Association of Social Workers (MASW) and UNICEF, aim to enhance the professionalism of care workers. Besides that, actions taken by KPWKM in enacting the Social Work Profession Bill, possibly this year[64], would improve the regulation of the profession and eventually enhance the prospects of social workers in Malaysia.

[63] LPPKN (2016)
[64] Malay Mail (2024)

The establishment of competency standards for social work, the enactment of the Social Work Act, and revisions to university programmes for social work are significant steps toward improving care work conditions in Malaysia[65].

Moreover, promoting gender balance in care work participation is essential. Care-related jobs should not be viewed as exclusively women's work; men must also be encouraged to take on roles as formal and paid caregivers. This shift in perception can enhance the value of care work and pave the way for women's leadership in the industry.

5.3. Enhance representation through social dialogue and collective bargaining

Many paid care workers face significant barriers to representation due to the nature of their employment, often working remotely or in informal settings. Consequently, their voices may go unheard in discussions about working conditions and labour rights. Encouraging participation in social dialogues and collective bargaining is vital for amplifying their concerns, advocating for their rights, and ensuring their needs are met.

In Malaysia, organisations like MASW serve as representatives for care-related workers, promoting professional standards and advocating for sustainable social services. However, there remains ample room for improvement in care workers' representation, particularly at the national level[66]. Establishing a comprehensive national association that encompasses all care-related workers can strengthen bargaining power and improve negotiation outcomes with the government.

Furthermore, including unpaid caregivers in representation efforts is crucial, as they face unique challenges and burdens in providing care. Ensuring that their voices are heard will enhance the visibility of their concerns among policymakers and regulators, ultimately leading to more equitable and effective solutions for all caregivers.

6. Conclusion

The Malaysian care workforce, encompassing both paid and unpaid caregivers, is essential for meeting the nation’s growing care demands and sustaining societal well-being. As this paper has highlighted, the sector is currently plagued by significant challenges including the disproportionate burden of unpaid care on women, underinvestment in training and development programmes for paid care workers, undervaluation of those working to provide care as well as a lack of decent work conditions for those in the care sector. These issues contribute to the perpetuation of systemic inequality and ultimately hampers the growth of the care economy. Amidst rapidly changing demographics, there is an urgent need for policymakers to establish a sustainable care system in Malaysia that not only meets the demands of the population but also promotes gender equality and social inclusion.

[65] JKM (2023)
[66] IFSW (2024)

First, **advancing the decent care work agenda for all care workers** is a non-negotiable. The ILO's Decent Work framework should be fully embraced, ensuring that all care workers—whether in formal or informal roles—receive fair wages, have adequate working conditions, benefit from robust social protection schemes and are provided opportunities for professional development. It is important to highlight that these efforts should focus on recognising the value of both paid and unpaid care work, particularly through the provision of support and interventions for women providing unpaid care. Additionally, policymakers need to focus on the incorporation of informal care workers into Malaysia's care framework alongside the establishment of comprehensive regulations that safeguard their working conditions. Collective bargaining and inclusive social dialogue must also be encouraged, giving care workers a stronger voice in shaping policies that directly impact their lives and livelihoods.

Second, **enhancing vocational and certification programmes** is crucial in ensuring that care work does not continue to be undervalued and undercompensated. Expanding these programmes for care workers, especially those in less regulated sectors such as *Residential Care* and *Social Care Work*, will have a dual impact of improving job prospects for workers while also improving the quality of care received by those in need. The enhancement of such programmes within the local workforce will also require significant investment, from both government and non-government employers, as well as effort to establish consistent certification standards.

Finally, there needs to be a focus on **promoting specialised care jobs through innovation and investment**. Under current circumstances, there is a high demand for semi- and low-skilled care workers, contributing to a false perception that work in the care economy is of low value. Thus, policy interventions need to leverage on technological advancements and encourage the adoption of innovative technologies in order to transition the Malaysian care sector towards one with a demand for higher-skilled roles. These efforts would also need to be complemented by investments by both the public and private sectors in high-quality care facilities and services that will be able to sustainably accommodate an increasingly skilled workforce.

The future of care work in Malaysia hinges on bold reforms that prioritise the well-being of both care recipients and caregivers, fostering a more equitable and sustainable care system that recognises the intrinsic value of care work. Now is the time for policymakers, employers, and society to come together and recognise care work for what it truly is, which is the backbone of a thriving and inclusive society.

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