# Towards Caregiving As Decent Work

## Changing Demographics and Disease Burden – a perfect storm

One of the megatrends in the world is population ageing. The Asian and Pacific region is ageing rapidly with the number of persons over 60 years old expected to more than double from 535 million in 2015 to about 1.3 billion in 2050. This demographic change would have resulted from sustained fertility decline and increased life expectancy. By 2050 , the population over 60 in all countries in the region is projected to increase with only 2 countries below 10 per cent i.e. Afghanistan ( 9%) and Timor Leste (8.1%) .

Ageing in the region can be characterized as occurring in "waves" , comprising the following:

(i)The first group of countries is the "aged" societies with over 40 % of the population over 60 years - Japan (42.5) , Republic of Korea (41.5) Hong Kong China (40.9 ) and Singapore (40.4).

(ii) The next group will be countries which are rapidly ageing such as China, Indonesia, Thailand , Vietnam

(iii) The third group will be countries with are ageing but at a slower pace

Detailed figures of all countries in the region can be found in the ESCAP Population Data Sheet (ESCAP,2016)

Population ageing will be characterized by the speed of ageing whereby (unlike countries in Europe where the ageing process occurred over a considerable time span) many countries will be getting old before they get rich. As countries will be at different stages of demographic transition with varying levels of economic

development, many countries will face financial problems with addressing the concomitant economic and social challenges of rapidly ageing populations

Coupled with the speed of ageing will be other demographic characteristics  -  the increasing number of the older old ( with higher probability of  frailty and vulnerability) , the feminization of ageing, the increasing number of  single elderly and the increasing number of elderly living alone . With the family being the traditional provider of care and support , changes in the family structure  of smaller family size and scattered families as well as increased female labour force participation will reduce the  capacity for care and support  provided by  family members especially female family members who in many cultures and are traditionally household caregivers, including eldercare.

The epidemiological transition from  infectious diseases to non communicable or chronic diseases will also require changes in the type of care and support including for long term care.
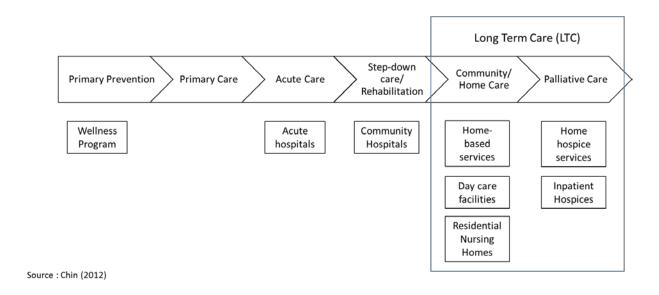
The convergence of the conditions and situations listed above  are leading to a "perfect storm" – presenting profound  challenges of an ageing population, especially for support and care

## The care continuum

Countries at all income levels  show very diverse patterns of long-term care in terms of balance of formal and informal services, the degree of state participation and the overall level of provision .

Care can be seen to be in a continuum, starting from prevention to primary care, acute care, step-down care /rehabilitation, community/ home care to palliative care. Primary healthcare is provided by the government, NGOs and the private sector. Intermediate and long-term care are institutional/residential or home and community based. Demand for care, especially long-term care is  set to grow more rapidly because of accelerated population ageing and increased prevalence of chronic diseases

# "Continuum of Care"



Source : Chin (2012)

There is a spectrum of services catering to acute, intermediate and long term needs. which is undertaken in institutional and non-institutional settings. There are essentially two categories of long term care services .The first is residential-based services which in some countries consist of community hospitals, nursing homes, respite care facilities , and hospice inpatient care

The second is community-based services which is largely utilized by those who prefer to stay at home or live in more familiar surroundings but need care and support. This category is further divided into (i) centre-based services like day care/rehabilitation centres, dementia day care centres, hospice day care centres , and (ii) home-based services which can cover home medical services, home nursing services, home help services and home therapy services.

The workforce is a spectrum ranging from highly skilled medical practitioners and specialists, allied health professions (especially physiotherapy, occupational therapy, diagnostic radiography, radiation therapy), nursing staff to informal paid and unpaid caregivers and family caregivers. There are also countries with community-based organizations like older people's association and intergenerational self help groups where volunteers are deployed to provide home

caregiving services.  There are also non-clinical staff in hospital operations and care coordination etc. as well as a category of care managers and workers in social care. (Kay,2017)


## The Decent Work Agenda

The concept of decent work was introduced by the  International Labour Organization (ILO)  in 1999 in the following terms  : "The primary goal of the ILO today is to promote opportunities for women and men to obtain decent and productive work in conditions of freedom, equity , security  and human dignity"(ILO, 1999).

The ILO has established four strategic pillars for the decent work agenda as follows: (i)Employment  (ii) Standards and fundamental principles and rights at work (iii)Social Protection (iv)Social Dialogue

A framework on measurement of decent work , comprising 11 indicators has also been proposed, as follows: employment opportunities; adequate earnings and productive work; decent working time; combining work, family and personal life; stability and security and work; equal opportunity and treatment in employment; safe work environment; social security; social dialogue, employers and employees representation; work that should be abolished; economic and social context (ILO 2008).


Against this background, a review of the human resources for caregiving shows a situation which falls short of decent work criteria.

## The Health Workforce

The International Labour Organization has estimated that there is a global shortage of  health workforce amounting to  18.3 million in the  health occupations and 31.8 million in the non-health occupations.   Out of the total global shortage, the Asian –Pacific region  shortages are estimated to be  56 per cent in the health occupations and  59 percent in non-health health occupations of the total global shortage (Scheil-Adlung 2016)

Almost all countries bemoan the shortage of human resources for providing health services , including long-term care.   The shortages have been attributed to supply

inadequacy deriving from an ageing workforce ( largely female), expanded career options for women, recruitment attrition and retention difficulties, and inadequate resources for research and education. Another cluster of discontent related to working conditions including working time ( long hours, shift work, overtime), unsafe working conditions (e.g . ''sharps', heavy duties causing injury), low wages and remuneration, low recognition and respect, and replacement by lower skilled assistive personnel (Nevidjon 2011 , Sasat 2013)

A study of the health workforce in the 10 Asean countries showed shortfalls with Cambodia, Indonesia , Laos, Myanmar and Vietnam below the WHO-defined critical shortage threshold ; weak coordination between production of health workers and capacity for employment; disparities in the distribution of health workers with concentration and better conditions in the urban and more prosperous areas.( Kanchanachitra 2011)

**Towards making carework decent work**

# LTC Human Resource Development

## LTC Human Resource Initiatives

| Ensuring Adequate Staffing | Ensure Competitive Pay | Raise Capability and Skills | Increase Efficiency and Effectiveness |
|---|---|---|---|
| • **Aged care manpower projections** (factor into pipeline planning)<br>•**Funding** to enable Nursing Homes to improve staff<br>•**Secondment Framework** for AHPs and Nurses<br>•**Alternative work arrangements** (e.g. part-time, flexi-work) | • **Job Evaluation Exercise** to determine relative job size vix. acute sector<br><br>•**Funding to address salary gap** | • Allow ILTC staff to pursue training in **advanced ILTC skills**<br><br>•**Facilitate training courses** for ILTC institutions<br><br>•**Funding** for locals to do degree-upgrading and basic ILTC training for all | • **Process Redesign / IT enablement**<br>•**Job Redesign** to enhance job value of nursing/therapy aides<br>•**Support technology** adoption and innovation to improve productivity<br>•**Demand Aggregation** to achieve economies of scale (bulk procurement) |

Source : MOH Singapore

## Reducing staffing shortage

Measures which have been taken focus on increasing the supply of caregiving staff especially nursing staff. The starting point should be a health human resource landscape study and health manpower master plan  Countries have reported schemes to increase the intake of students , although outcomes have not been encouraging unless undertaken with expanded facilities and availability  of qualified faculty . With the view to addressing problems of attrition and retention schemes have been established for career progression, professional development and recognition, and enhanced pay and improved working conditions There are also schemes to recruit part time Basic Care Assistants to free up nurses for clinical duties, professional conversion programmes to convert other disciplines to healthcare etc . There are also been  return-to- nursing programmes to enable nursing staff to return to their profession after undertaking refresher training, secondment to other settings requiring care such as from acute hospitals to community-based settings etc

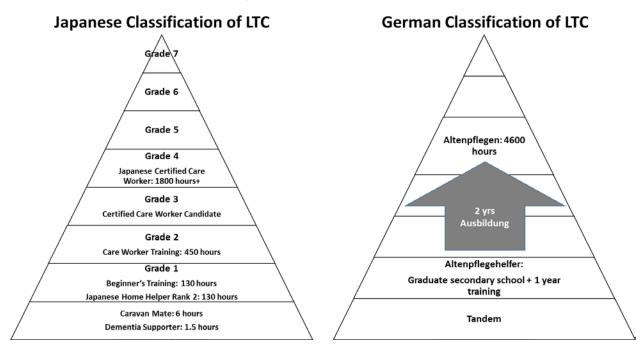## Raising capabilities and enhancing skills

Training of caregivers is available in many forms and as shown below, countries have their own training programmes with different contents and level of skills and competency. While the differences among training programmes  may be too diverse to standardize and harmonize, experts in this field have advocated for national standards, training based on core competencies, certification of care workers, accreditation of curriculum  and the need for a career ladder. In some countries, domestic helpers can avail of caregiving training  , sometimes with government subsidies.  Some  caregiver training programmes are as follows:

Republic of Korea – yo-yang-bo-ho-sa ( 240 hours – 80 hours theory, 80 hours practical exercise, 80 hours in nursing homes)

Singapore -  WQS certificates ( training by designated training providers)

Philippines  - TESDA elder care certificate

# Long Term Care (LTC)

## Japanese Classification of LTC

Grade 7

Grade 6

Grade 5

Grade 4

Japanese Certified Care Worker: 1800 hours+

Grade 3

Certified Care Worker Candidate

Grade 2

Care Worker Training: 450 hours

Grade 1

Beginner's Training: 130 hours

Japanese Home Helper Rank 2: 130 hours

Caravan Mate: 6 hours

Dementia Supporter: 1.5 hours

## German Classification of LTC

Altenpflegen: 4600 hours

2 yrs Ausbildung

Altenpflegehelfer:

Graduate secondary school + 1 year training

Tandem

## Improve working conditions

Poor working conditions is one of the most common causes affecting attrition and retention of careworkers.  In this regard, international labour standards are available to provide benchmarks.  Relevant ILO conventions for caregiving would include Conventions  106, 132, 149 ( nurses), 156 ( family responsibilities ) 171 and 175.

There are also relevant national labour laws and standards governing working condition, although in many countries abiding by the law and prosecuting non-conformity would be a challenge.

There are also trends towards improving working conditions such as moving from 3 eight hours work shift to  2 twelve hours shifts

Flexiwork  including flexi-time , part time work, job sharing would also provide alternatives and options for improving working hours.

## Addressing low wages and remuneration

In many countries, especially developing countries, the issue of low wages  and remuneration are crucial to the retention of the caregiving workforce.   As caregiving covers a spectrum of health workers, large wage variations reflect skill levels, qualifications and education.

Measures for determination of wage levels would include job evaluations covering job size and scope .   Enhancement of wage levels would also be brought about by skills upgrade, progression up the career ladder etc.

With the current need and shortage of caregivers, wage levels can leverage on the market-place at the local, national and even global level

As caregiving  is often perceived  as "female work' and thus undervalued, measures to challenge this perception as sexism can be explored, possibly in collaboration with gender advocates  and experts.

## Technology

In caregiving,  technology will provide the tools to increase efficiency and effectiveness , and enable caregivers to add value to their work.  Technology can enable processes to be redesigned such as through analytics .  Job redesign can ease physically demanding task and minimize injuries. Technology can also reduce geographic barriers  such as the urban-rural divide, and facilitate inter-professional collaboration.   Telehealth, telerehabilitation, telemonitoring, surveilllance can play important roles in caregiving. Other advances will be innovations in e-learning , communications, and digital healthcare market place .Although there will be obstacles of privacy and digital exclusion and lack of literacy among the elderly, technology has the potential to propel  caregiving into decent work with enhanced skill levels and better working conditions

## Social Protection

Governments in the Asia and Pacific region are strengthening social protection coverage. 21 out of 26 countries ( for which data is available) have increased social protection spending in the last two decades.   However, only 30 per cent of persons above retirement age receive an old age pension. 8 out of 10 workers are not covered under a pension scheme.

Pension schemes are fragmented with a mixture of military/civil service and formal employment schemes as well a small informal sector scheme and in some countries, also a social pension scheme

80 per cent of the population in the ESCAP region have no access to affordable health care and out of pocket health expenditures are among the highest in the world

Proposed measures to enhance social protection include anchoring social protection in a rights-based foundation, prioritize investments in social protection, strengthen taxation systems to finance social protection and explore innovative financing measures such as using sovereign wealth funds, "sin tax" (ESCAP 2011)

## Social dialogue

Caregivers are organized in various forms:

(i)Professional bodies and councils – medical councils, nursing councils ,which serve for certification, standards setting, disciplinary action, negotiations on working conditions

(ii)Organizations of other heath service personnel e.g. Healthcare services employees union

(iii) Organizations/collectives/networks of domestic workers , migrant domestic workers( e.g. Migrant Workers Rights Network for migrant workers from Myanmar working in Thailand) which serve roles of protection, and advocacy

Engagement in social dialogue and consultations between members and employers although undertaken, are often guarded. In some countries, common industrial action such as protests and demonstrations are strongly discouraged or regulated. Context is thus very important for collective action and social dialogue

## Conclusion

As caregiving covers a spectrum of health workers, it would appear that at the higher skill end, medical personnel like physicians can be considered to have decent work. However, for the majority of caregivers, the four strategic pillars of the decent agenda would require policy changes and support from multistakeholders before caregiving can be considered decent work.

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