THE RE:CARE PROJECT

Towards developing resilience in the care workforce:
Lessons from COVID-19 in Malaysia

Policy Brief 2: Care Ecosytem Resilience

This brief complements our earlier analysis on care workforce resilience, shifting focus from individual and organisational wellbeing to the broader care ecosystem.

This policy brief was compiled by Anis Farid, based on the "Towards A Resilient Care Workforce: Lessons from COVID-19 in Malaysia" report authored by Anis Farid, Shazana Agha, Shanthi Thambiah, Denise Spitzer, Wani Hamzah, Alicia Lee Syin-Syin, Ilaiya Barathi Panneerselvam, Yu Ren-Chung, and Abinaya Mohan. Layout and design by Monica Theseira. Cover art by Shamini Boovanasan.

Executive Summary

The COVID-19 pandemic was a crisis that had a profound impact on Malaysia's care ecosystem. In an effort to strengthen this ecosystem and better understand the context of care work in Malaysia, our work investigated the experiences of essential care workers undertaking their paid and unpaid care responsibilities, and the impact on their wellbeing. Our large-scale, nationwide study undertook a mixed-methods approach, influenced by participatory principles, involving 144 women care workers across 24 focus group discussions, complemented by a quantitative survey with 1,534 men and women care worker respondents, and 20 key informant interviews with policy-adjacent stakeholders across government and civil society.

Our findings revealed:

1. *Wellbeing among care workers declined during the COVID-19 pandemic and has not fully recovered.* Most importantly, *Malaysian women's recovery lags behind their Malaysian men and migrant women counterparts.* The gap between Malaysian men and women is especially telling: Despite similar contexts, women report poorer wellbeing outcomes, reflecting persistent gender norms and structural inequalities that meaningfully shifts especially how unpaid care work is experienced.
2. *There are high rates of intention to leave their current position within the next five years amongst care workers* (34.5% amongst Malaysian care workers; 56.5% amongst domestic workers), which is concerning for the long-term sustainability of Malaysia's care ecosystem.
3. *Strengthening resilience is crucial for care workforce retention,* as modest improvements in individual resilience increases the odds of a care worker staying in their current position by 33%, whereas improved organisational resilience increases the odds by 112%.

These findings demonstrate the importance of initiatives to enhance the resilience of the care ecosystem, which is the system's ability to ensure continuity, quality, and accessibility of care through shocks and transitions.

Thus, **we recommend investing at least 1% of GDP (RM39.6 billion)** to support the following:

1. *Integrate care workers and care work within crisis-preparedness and response plans.* Designate care workers as essential workers during crises, so they may be protected with resources, access unrestricted mobility while in service, receive adequate hazard-related compensation (e.g. risk and hazard pay) and access crisis-specific facilities and services (e.g. transportation, childcare or elderly care services, temporary housing). Develop clear and comprehensive crisis-specific SOPs that span across all care sectors (healthcare, social care and domestic care), and entire chains of command. Ensure care workers regularly participate in preparedness training prior to national emergencies or crises.

2. *Ensure sustainable financing of care policies including crisis preparedness.* It is not possible to bolster the resilience of care workers and the care ecosystem without sustained, strategic investments. Care must be an economic priority, with investments across the short, medium, and long term to strengthen the care workforce and build resilience across individual, organisational, and national levels.

3. *Strengthen governance and coordination for a coherent care ecosystem,* by institutionalising a national multi-sectoral coordinating entity which could oversee the development and implementation of a national care

strategy and the integration of our health and social care systems. This entity could also play a critical role in carrying out strategic care workforce planning as well as resolving long-standing coordination issues within care sectors.

Background and Context

The environment within which care work, its actors, network and structures occur has often been referred to as either the *care economy, care sector, or care ecosystem.* While these terms are often used interchangeably, in Table 1 below we highlight some differences between these interconnected concepts.

TABLE 1

Definitions of the Care Economy, Care Sector, and Care Ecosystem

Care Economy	*Encompasses all activities related to the provision of care, including paid and unpaid care work for present and future populations. This term emphasizes the valuable contributions of caregiving activities to the economy and is underpinned by an economic lens of productivity.*
Care Sector	*Refers to formal care services (e.g. within healthcare or social care) in both public and private sectors. This term is often used to focus more narrowly on policies, regulations and frameworks that govern the care sector.*
Care Ecosystem	*Refers to an interconnected network of individuals, organisations and systems involved in paid and unpaid care work. The term is often used to highlight the importance of approaching care from an* ***integrated and collabourative approach*** *(e.g. social care, healthcare, and also personal care capacities/responsibilities), leveraging the* ***multiple levels of resources and networks*** *within a care context (e.g. family, community, service providers, government) to meet the needs of care recipients and support those who undertake paid or unpaid care work.*

Source: The Asia Foundation 2022; UN Women and International Labour Organisation 2021; Peng 2018; UN 2024; The Centre for Care 2025.

Malaysia faces a convergence of care crises, ranging from epidemiological shifts from a growing ageing population, to a shortage of care workers. Despite Malaysia's stance on reducing reliance on foreign labour, many care sectors remain unattractive to Malaysians, an issue worsened by high dropouts across care sectors. Ensuring the resilience of Malaysia's care ecosystem requires more than physical infrastructure—it demands close examination of the experiences of care workers to contextualise where support must be strengthened. This, in turn, will secure the sustainability of available care services through shocks.

Essential care workers included in this study are those from the following sectors and occupations:

TABLE 2

Categories of Essential Care Workers Included in the RE:CARE Study

Healthcare

- *Doctors*
- *Nurses*
- *Hospital cleaners*

Social Care

- *Social workers*
- *Childcare providers*
- *Specialised care providers* (*those providing care for the elderly or people with disabilities*)

Domestic Care

- *Domestic workers from Indonesia*
- *Domestic workers from Philippines*

The COVID-19 pandemic played an important role in underscoring the need for strong care systems and comprehensive disaster preparedness plans. At the heart of these systems are care workers, predominantly women, who are often tasked with ensuring the continuity of care amid high levels of uncertainty. A truly resilient workforce, however, is able to provide continuity of care without significant personal costs to workers' mental health and wellbeing. Unless Malaysia begins to rethink its support for care workers, and review how care is addressed and prioritised within the nation, future crises will potentially result in negative impacts on the care workforce and strain our already fragile care ecosystems. In this, we view care workers across all three sectors—healthcare, social care, and domestic care—as essential because they are engaged in services critical to the functioning of society (Berry and Stuart 2021; Guerrero et al. 2020).

There are five key issues that remain underaddressed, which pose risk to the sustainability of the care ecosystem:

1 *Lack of professional development opportunities and inadequate career progression pathways*

The care workforce often have limited access to training and career advancement opportunities. This affects their ability to progress within the sector or to transition to other, higher-paying fields. As care sectors are often feminised, women bear the brunt of this inequality, reflected in how spaces such as the medical faculty, or even the boards of early childhood care and education, often have a lack of female leadership.

The lack of formal structures for career advancement is underpinned by a lack of support and standardised training, certification, and professional growth, leading to "dead-end" roles. Without clear career pathways, workers—primarily women—often remain in lower-wage positions without

opportunities to progress to higher-paying roles. Consequently, there are high turnover rates within the paid care sectors, constricting the growth of the care workforce.

2. Lack of adequate compensation and recognition, leading to the undervaluation of care work

The care sector in Malaysia is largely undervalued, with care work often seen as an extension of unpaid domestic labour traditionally performed by women. This perception results in lower wages and limited benefits for care workers. Current policies lack provisions to standardise fair pay and benefits for care roles, perpetuating the view that care work is "secondary" labour that does not warrant the same remuneration as other sectors. This reinforces gendered economic inequalities, particularly as care sectors have high representation of women workers. Consequently, those in caregiving roles often have minimal benefits and a lack of opportunities for career advancement and growth, leading to poor job security.

3. Lack of social safety nets for care workers, especially in old age

Women, who make up the bulk of formal care workers, generally have different patterns of labour force engagement compared to men. For example, women typically take longer career breaks and are usually segregated into underpaid sectors, such as those within the care ecosystem. Consequently, women tend to have lesser savings or pensions compared to men. This is worsened by precarious employment, which is often faced by certain care workers, such as hospital cleaners or domestic workers.

As it is, over 90% of EPF members under the age of 30 do not have enough savings to meet the basic retirement savings target of RM240,000 by age 55, in part due to the COVID-19 pandemic (KRI 2024). There is also a growing trend of poverty in old age in Malaysia (Awang 2023). Given the undervaluation of formal care work, women engaged in this sector face financial vulnerability as they age, even if they are long-tenured.

4. Women's representation in leadership roles within care sectors remains limited

Traditional gender roles often cast men as primary breadwinners and position women as family nurturers. Despite some progress, these gender biases persist. The care sector in Malaysia is still defined by these traditional perceptions, which can further discourage men from entering caregiving professions. The presence of fewer female mentors and role models in senior positions within care-related fields also limits women's professional growth and restricts networks critical for career advancement. In the Malaysian workplace, women generally face limited opportunities for career growth, where they are less likely to be promoted compared to their male counterparts (Moorthy et al 2022). Gregor and O'Brien (2016) stated that women remain underrepresented in management positions, even in fields which have been historically dominated by women, such as in "feminine" professions within the care sectors (cited in Moorthy et. al 2022).

5 Care remains under financed

The persistent underfinancing of care systems, identified by the World Health Organization (WHO) (2024), "results in a vicious cycle of unpaid health and care work, lowering women's participation in paid labour markets, harming women's economic empowerment and hampering gender equality." In Malaysia, the underfinancing of the care workforce and infrastructure is a critical issue, with compounding impacts. As it stands, Malaysia's investments in care are heavily reliant on individual ministry-related financing and budgetary needs. In the 2021 Voluntary National Review, it was noted that many implementing agencies are underfunded (Economic Planning Unit 2021). Underfunded public resources, unable to keep pace with public demands, effectively transfers the responsibility to private households, reinforcing gender inequalities perpetuating informal care as women's responsibility.

Resilience is defined as systematic agility or resourcefulness to "anticipate, adapt and reorganise itself" and "retain control over its structure and functions" (e.g. continue delivering critical services, maintaining the wellbeing of its workers) while facing shocks or crises (Blanchet et al. 2016, 432; Ungar 2018, 1). How systems, networks or actors respond to adversity or shocks is often described through three levels of resilience capacities or strategies—absorptive, adaptive and transformative (Barasa et al. 2017; Blanchet et al. 2017; Haider and Cleaver 2023). These capacities may occur at the individual, organisational/employer or systemic level.

TABLE 3:

Definitions of the Types of Resilience Capacities

Absorptive capacity	*The ability to absorb and bounce back from shocks in the short term; typically thought of as the ability to withstand or absorb stresses and shocks.*
Adaptive capacity	*The ability to learn from and adapt to "a range of environmental and social contingencies".*
Transformative capacity	*The ability to "shift to a substantively new system, often intentionally, and involving priorities different to the status quo, leading to changes across multiple scales."* *Generally refers to **structural shifts** (e.g., policy, institutional, infrastructural changes, social norms change) that bring about change and enable individuals or communities to respond more effectively to a changing environment (Jeans et al. 2016).*

Source: Haider and Cleaver 2023

This framework of resilience capacities helps us analyse how care workers respond individually to crises like the pandemic, and to identify points at which systems, organisations and employers must evolve to support care workers' capacities in a more sustainable and equitable manner, while taking into consideration specific vulnerabilities arising from care workers' social identities (e.g., women, migrant workers, persons with disabilities and those with significant unpaid care work loads). In this policy brief, focused particularly on the care ecosystem, when resilience is mentioned, transformative capacity is the most relevant, as recommendations hinge on structural shifts which would better support the wellbeing of careworkers and, thus, the overall ecosystem in which they are embedded.

Key Findings and Policy Recommendations

Three-fourths (75.7%) of the care workforce surveyed experienced a decline in wellbeing during the COVID-19 pandemic, with two-thirds (67.5%) of these care workers still not recovering to pre-pandemic levels of wellbeing.

FIGURE 1

Three in Four Care Workers (75.7%) Were Hit by this Decline in Wellbeing (n = 1,534).

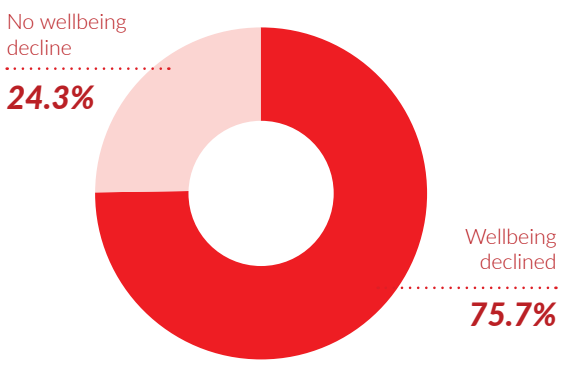
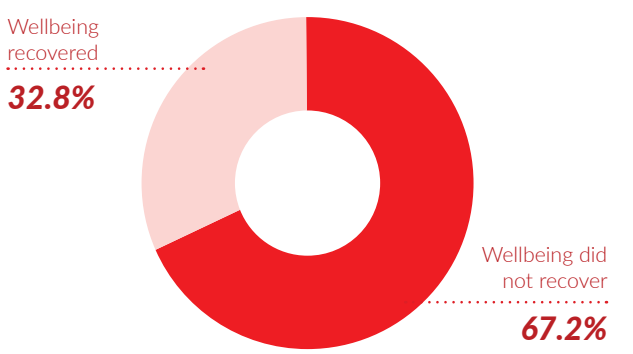
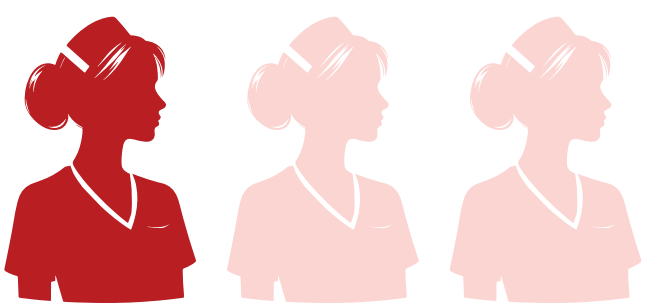


FIGURE 2

Of These, Two in Three (67.2%) Have Not Recovered to Pre-pandemic Levels of Wellbeing (n = 1,161).



Importantly, our findings demonstrate that *adequately supporting the retention of our care workforce and addressing gender gaps in wellbeing outcomes requires strengthening both individual resilience and perceived organisational resilience,* that is how supportive and responsive care workers perceive their organisations.

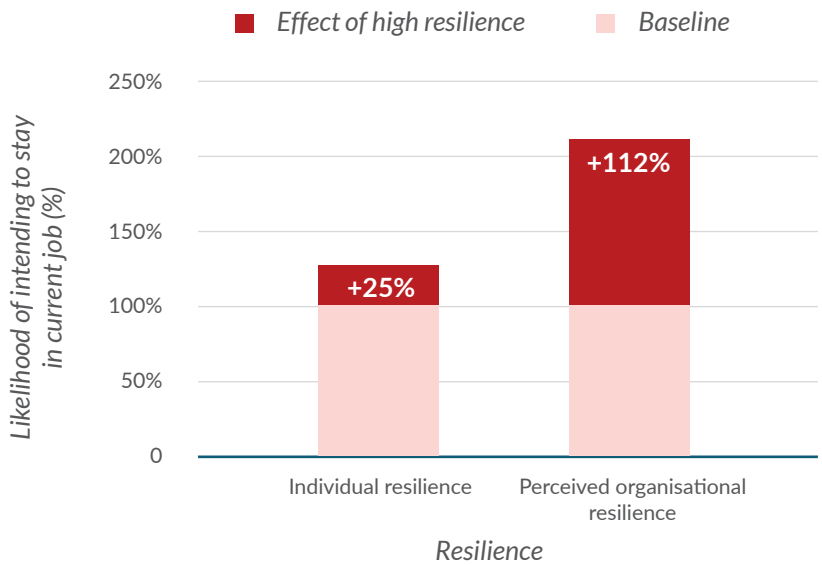


***1 in 3** Malaysian care workers (34.5%) are thinking of **leaving their current positions** within the next five years*

Care workers with higher individual resilience were *25% more likely to intend to stay in their jobs,* even after accounting for organisational factors. Those who perceived their organisations as resilient were *112% more likely to stay.* Together, this underscores the importance of bolstering resilience.

FIGURE 3

Having High Individual Resilience and High Perceived Organisational Resilience Increases Intention to Stay. (n = 1,534)



NOTE: The baseline is assumed at 100%, to demonstrate the effect of high resilience more clearly.

Broadly, our recommendations are guided by the International Labour Organization (ILO) 5R Framework for Decent Care Work.

TABLE 4:

The 5R Framework for Decent Care Work.

Recognise	***Recognise** the value of care work and the rights of care recipients, care workers, and caregivers*
Reduce	***Reduce** labour-intensive unpaid care work through investments in infrastructure, technology, and services*
Redistribute	***Redistribute** unpaid care work more equitably between genders, and between households and the state, businesses and community*
Reward	***Reward** paid care workers with decent wages, fair allowances, and social protection*
Representation	***Representation** and meaningful participation of care workers, caregivers, and care recipients in decision-making*

Source: ILO. (2018). Care work and care jobs for the future of decent work; United Nations. (2024). Transforming Care Systems in the Context of the Sustainable Development Goals and Our Common Agenda.

In order to strengthen the resilience of the care ecosystem, we propose the following:

STRATEGIC PILLAR 1

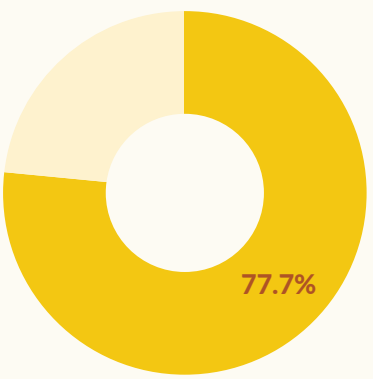
Integrate care workers and care work within national crisis preparedness and response plans[1]

The COVID-19 pandemic was sudden and disrupted normal routines and processes, forcing institutions, workplaces, and workers to navigate high levels of uncertainty. For care workers, who had to work during the lockdown, this pressure was two fold: They faced heightened stress as they sought to respond to shifting demands of their paid work, while having to ensure personal care arrangements for their families and loved ones.

To support care workers in future crises, *integrate care workers and care work into national crisis preparedness and response plans.* Governments must *recognise the importance of care work in times of crises,* and consider classifying all care workers (not just clinical workers) *as essential workers.* In this, we emphasise that national crisis preparedness and response plans should not focus merely on the provision of emergency services to the nation but also on securing the wellbeing and needs of the care workforce, tasked to deliver such critical services. This would promote ecosystem resilience by directly addressing the issues faced by care workers during the COVID-19 pandemic, taking lessons learned from the crisis to ensure care workers are better supported in the future.

Relevant Findings

Having a comprehensive disaster management plan is important to three-fourths of health and social care workers surveyed (77.7%).



In our FGDs, care workers reported that unclear SOPs and directives, a lack of resources, and poor inter-sectoral understanding led to confusion and stress over how to manage care recipients within their specific care contexts.

Care workers also shared that having a comprehensive disaster management plan not only includes the SOPs for how to handle certain disasters, but also a cler method of disseminating and communicating directives across relevant sectors and entire chains of command. A *lack of training* made it difficult for staff, especially more junior staff, to handle COVID-19 protocols and cases, as shared by care workers in FGDs.

Two-thirds of health and social care workers surveyed (69.2%) *want formal recognition of care workers as essential workers.*

One-third of social care workers surveyed (35.6%) feel that *infrastructure should consider the wellbeing of care workers* (e.g. rest and recovery spaces for decompressing during long shifts).

1 While this is referred to as Pillar 1 in this policy brief, in the full report, this is Pillar 3.

A Review Crisis Preparedness Plans and Strengthen SOPs, Guidelines, and Communication Protocols.

Anna, Nurse, East Malaysia

Kalau dari segi organisasi, apa yang saya cadangkan... Siapa saja yang jadi ketua, kena ada satu panduan untuk, bagaimana arrangement sekiranya berlaku pandemik. Contohnya kalau ada sudah step. Kalau ada pandemik lagi, kita buat dengan ini. Sebab dia baru, jadi kucar kacir.

English translation

If from an organisational lens, what I recommend is... whoever is head, they need to have a guide for what the arrangements are should a pandemic happen. For example, if there are steps, and if there is a pandemic again, we could just use it [the guide]. Because it [the pandemic] was new, things were haphazard.

Since the pandemic, Malaysia has embarked on a process of consolidating earlier guidelines on disaster management to ensure a more coordinated, whole-of-government and whole-of society approach to future crises. These ongoing efforts have resulted in the NADMA Strategic Plan 2024-2028, as well as Arahan NADMA No.1 published in 2024, signalling government attempts to address coordination gaps exposed during the pandemic.

Existing national crises preparedness guidelines and standards should be reviewed and strengthened, to ensure smoother processes and clearer scopes of work for care workers. The following have been highlighted by care workers as areas for strengthening crisis preparedness:

1. *Strengthen institutional/organisational crisis preparedness plans:* Upgrade crisis preparedness plans by integrating revised national guidelines and standards, aligned with setting-specific risks (eg. hospitals, childcare centres). Frontline care workers should be engaged to ensure guidelines reflect real operational challenges.

2. *Integrate care workers into national crisis preparedness and response frameworks:* Shift beyond agency-focused preparedness toward an integrated care ecosystems approach. Line ministries and implementing agencies should develop SOPs and response plans encompassing care workers across public and private healthcare, social care, and domestic care, considering those in less formal care settings too (eg. private care homes, community-based care, and migrant domestic workers in private homes). This aligns well with NADMA's whole-of-society approach and Malaysia's Sendai Framework commitments.

3. *Institutionalise disaster preparedness and emergency response training for all care workers:* Upgrade crisis preparedness training modules to ensure relevance and reduce confusion in crisis response. Standardised indicators and protocols (e.g. when X happens, Y protocol begins) should be introduced to enhance predictability and understanding of when a new set of SOPs should apply (Institute of Medicine 2013). These trainings should be embedded within national training frameworks and complemented with regular drills and refreshers tied to accreditation.

B Ensure Crisis-Specific Support for Care Workers are Available and Accessible.

There were several key gaps in government aid, for both care workers, and institutions, which were raised by care workers themselves as well as key informants. To address these issues, the government must:

1. *Ensure government emergency support reaches all social care providers:* During COVID-19, access to government aid for social care was uneven, complicated by the large informal and unregulated landscape of care centres in Malaysia. To ensure more comprehensive inclusion, eligibility could be broadened beyond LHDN filings to include EPF or SOCSO registration. This can help ensure more taskas are able to access aid. Simultaneously, extending vaccinations to unlicensed care centres offers a positive model to replicate in future crises. Moving forward, those in informal sectors should also receive emergency support including financial aid, sanitation supplies, and personal protection equipment (PPE).

2. *Ensure fair distribution of critical allowances:* One-off or unequal disbursements were a point of frustration for care workers during COVID-19. Critical personnel, such as social workers, who were responsible for food basket distribution, supporting quarantine efforts, and responding to escalating cases of domestic violence and child abuse, as well as hospital cleaners, who were directly exposed to biohazards working alongside other healthcare staff, were, at best, given one-off disbursements. Over 85% of health and social care workers surveyed agreed that special allowances should be distributed more fairly in future emergencies.

Social Worker, Malaysia

Memang kita bantu rakyat ya, memanglah itu one of the tanggungjawab kita kan, tapi biarlah setimpal. Sekurang-kurangnya, kalau dapat elaun kritikal dalam RM 300 sebulan, sepanjang tempoh pandemik tu berlaku pun, satu bulan RM 300 tu pun kami rasa dah macam, "eh at least ada lah juga orang top up sikit", kan? Kita pun rasa eh, people pun appreciative kita....

Orang memandang kepada contoh, saya mengambil senario orang memandang kepada polis, memandang kepada hospital dan kerana mereka ni adalah merupakan salah satu golongan kumpulan professional. Yang kita yang [social worker] ni tadi tu sipi-sipi, terpinggir. Walhal, yang on the ground betul-betul, mereka ni lah tadi tu yang duduk dekat apa hotel PUS, nak kena hadap rakyat kita....

English translation

It's true that [it is our duty] to help the people, ya, and that is certainly one of our responsibilities, but let it [the compensation] be proportional. At least, if we get critical allowances of RM300 a month, throughout the duration of the pandemic, one month [just] RM300, that would make us feel "eh there is at least some top up" right? We would feel that people are appreciative of us too.

People look up at, for example, the police, to the hospital because they are from the professional grouping. We who are [social workers] are sidelined. When the people who are really on the ground, they are the ones who sit at the hotel PUS [hotels used as quarantine centres], we have to face the people...

Vijahah, Hospital Cleaner, Central Region

Yes, everyone should be treated equally. We are cleaners. The hospital is clean because we, the cleaners, are doing our job. If we weren't there, would the hospital be clean? So, whatever benefits they get, we should get too. But if we ask, they'll say they are government employees, and we are contract staff.

3. *Provision of safe spaces and transportation during crises:* During the pandemic, some care workers opted to stay away from home to protect their families. In focus group discussions, women care workers often felt conflicted in undertaking their professional roles while bearing unpaid care responsibilities within their households. Transportation also presented another major challenge, especially for those relying on public transportation, which were reduced during movement control orders (MCOs). Others still faced challenges at roadblocks because their frontline status was not recognised. Future preparedness measures should include:
    a. Temporary accommodation for care workers unable to return home;
    b. Dedicated transport or travel subsidies for shift workers;
    c. Special passes or formal documentation for all care workers to navigate roadblocks or cross-state travel

C ***Establish Temporary Care Arrangements During Crises.***

Designate particular care centres as temporary childcare centres during crisis to support essential care workers. During the COVID-19 pandemic, closure of childcare centres left many essential care workers without safe childcare options. Notably, during this time, the Selangor government initiated a programme called the Frontier Child Care Initiative (iPAF) aimed at offering child care services for medical workers on the frontlines (Farah Solhi 2020). This should be institutionalised as a good practice and automatically made available for all care workers to enable a redistribution of personal care responsibilities to state-led programmes, especially during crises.

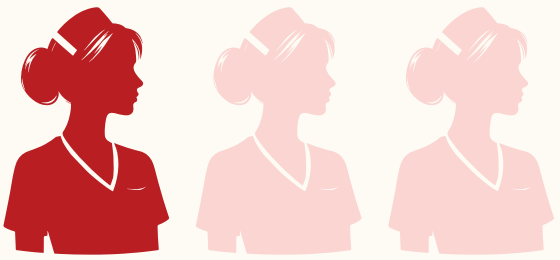
STRATEGIC PILLAR 2

Bolster investments in the care ecosystem to improve the wellbeing and resilience of the care workforce[2]

Care must be seen as an *economic and financial priority,* worth investing into for the future-proofing and crisis-preparedness of our country. Our findings demonstrate investing in organisational resilience, ensuring that workplaces are not only able to meet the needs of its clients, but also its workforce, can support care workforce retention. Care financing must go beyond infrastructure and service delivery to explicitly include the needs of care workers. Investment in the care ecosystem must be strategic and sustained, recognising *that workforce wellbeing is a prerequisite for care system resilience.*

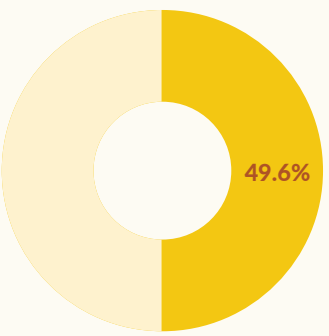
2 While this is referred to as Pillar 2 in this policy brief, in the full report, this is Pillar 4.

Relevant Findings

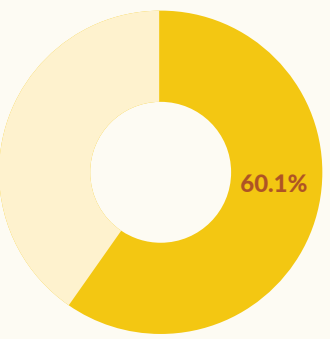


Stronger investments into the care workforce are required to improve care workforce retention, as currently one in three Malaysian care workers (34.5%) intend on leaving their current positions within the next five years.

The care workforce requires sustained financing as:



Half of care workers surveyed (49.6%) *feel there must be more government support and/or investment in their sector.*

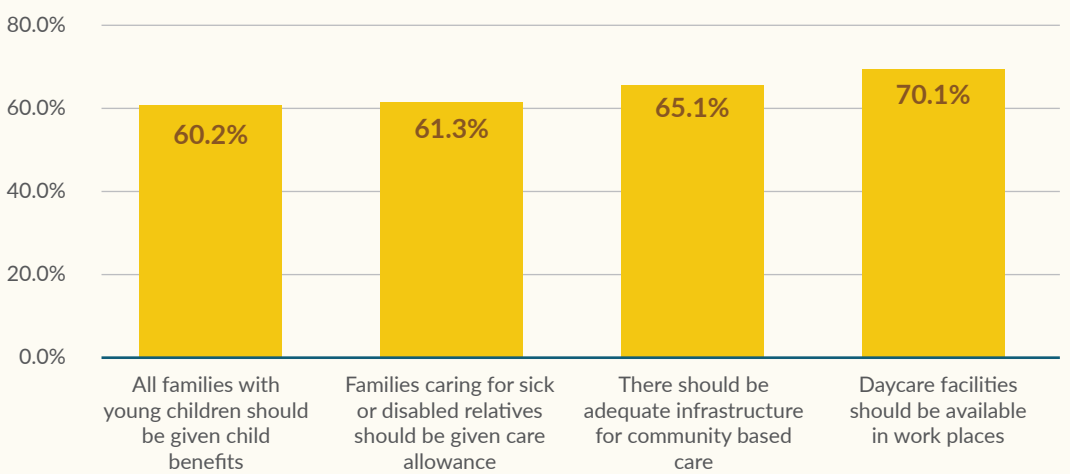


Nearly two-thirds of care workers (60.1%) *feel their workforce must be bigger.*

Simultaneously, initiatives shifting unpaid care work from a personal responsibility to a co-responsibility, with increased support from the government, are highly supported by care workers:

FIGURE 4

Care Workers' Priorities for Investments Towards Co-Responsibility (n = 1,221).



Largely, key gaps need to be bridged in order to better support the care workforce in Malaysia. In the short and medium term, investments must be made to ensure the following:

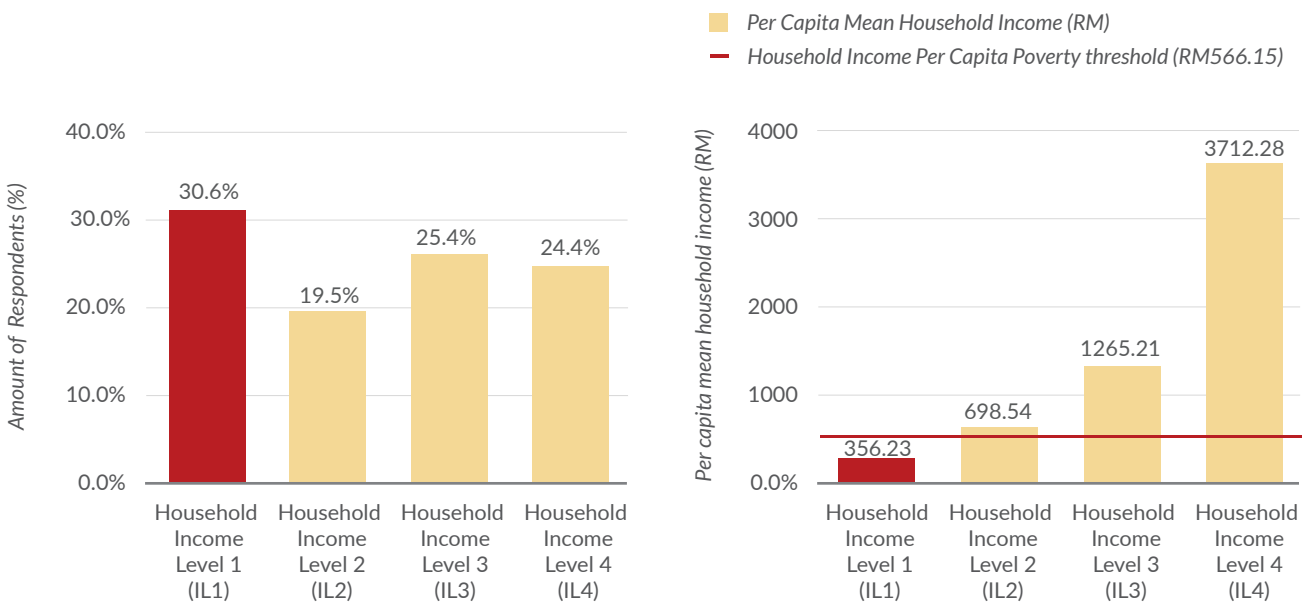
1. *Increased human resource*
2. *Improved salary structure and benefits*
3. *Upskilling of care workers*
4. *Enhanced support for care workers' unpaid care work, including investments into community-based care.*

The above reflect key concerns of care workers, namely in expanding the care workforce, ensuring fairer remuneration, and receiving adequate support for unpaid care responsibilities. Based on our findings, investing in these aspects can improve the wellbeing of care workers, potentially improving retention.

While short and medium term investments are crucial to strengthen the care workforce and infrastructure, long-term investments must also be strategised simultaneously. In the long term, financing old-age pensions should be prioritised, as many care workers remain in lower socioeconomic classes, with 59.3% of care worker households explicitly falling into the B40 category. Closer inspection of care worker households reveals larger disparities when examining per capita household income, with nearly one-third of care worker households surveyed (30.6%) having an average of RM356.23 to spend per person, far below the per capita household income poverty threshold of RM566.15.[3]

FIGURE 5

The Largest Share of Care Worker Households Fall into the Lowest Household Per Capita Income Bracket (IL1) (Right). These Households Have, On Average, RM356.23 to Spend Per Household Member, Below the Household Income Poverty Threshold of RM566.15 (Left) (n = 1,534).



3 Poverty income threshold comes from DOSM (2020). Per capita household income was used to better assess the invisible poverty care worker households face, that may be masked by salaries which may be higher than minimum wage, but must be split amongst a large number of dependents. More details are available in Finding 1 of the full report, "Towards a Resilient Care Workforce: Lessons from COVID-19 in Malaysia."

STRATEGIC PILLAR 3

Strengthen Governance and Coordination for a Coherent Care Ecosystem[4]

A strong workforce cannot exist without a coordinated and well-resourced care ecosystem. Building that ecosystem requires clear leadership and coordination across ministries. While there have been many recent initiatives to promote the development of the care economy, these efforts are fragmented, lacking a whole-of-government approach and a consideration of long-term planning for the care workforce.

We recommend establishing *a national coordinating entity,* such as a National Care Commission or a Special Select Committee on Care that would report to Parliament, supported through an inter-ministerial taskforce. This entity should provide oversight and leadership on care-related policies and initiatives, ensuring policy coherence across sectors and alignment with national priorities. While support for care workers at an individual level is important, structural reforms and systemic change will bring the most impact, enabling better retention of a skilled care workforce, thereby fostering ecosystem resilience.

As part of its scope of work, the coordinating entity should focus on matters pertaining, but not limited, to the following:

1. *Develop and oversee implementation of a National Care Strategy and Plan:* Align existing efforts through a unified strategy and policy framework, clarifying roles and responsibilities across various ministries, agencies and other actors. Establish common standards and clarify roles for stakeholders. These efforts ensure an integrated, systematic, and gender-responsive care ecosystem with continuity beyond electoral cycles.

2. *Resolve long-standing coordination and alignment issues* within the care ecosystem that requires closer multi-sectoral collaboration. This includes streamlining registration and licensing processes, harmonising social protection protection programmes operating across various ministries, and unifying early childhood care governance.

3. *Lead national care workforce planning, premised on a forecast of Malaysia's care needs.* Care workers want more systematic, forward-looking planning. Evidence-based planning is central for efforts towards effective workforce planning.

4. *Address systemic gaps and structural barriers to ensure retention of a skilled workforce.* Address existing barriers to retention through training, certification, fair wages, and clear career pathways. This would elevate care work into a sustainable, respected profession, supporting talent attraction as well.

5. *Develop an integrated data system and monitoring framework across ministries to enhance evidence-based decision making.* Linking care demand with workforce supply through a gender-disaggregated data system would allow policymakers to anticipate future care demands and appropriately respond without risking workforce wellbeing. These efforts require close collaboration between ministries, agencies, and stakeholders at state and district levels.

4 While this is referred to as Pillar 3 in this policy brief, in the full report, this is Pillar 5.

6. *Promote better integration of health and social care systems.* In Malaysia, health and social care systems function largely independently. Integrated models of care delivery have the potential to ensure that individuals receive holistic, person-centred support that addresses both medical and social needs. Joint training programmes, inter-agency placements, and competency frameworks that bridge both sectors can help foster shared understanding and collaborative practice. For care workers, better integration of health and social care systems can make workloads more manageable by enabling further clarity of roles, reducing bureaucratic inefficiencies, improving coordination across teams and enhancing multidisciplinary support.

7. *Ensure recognition of the domestic care sector and strengthen the protection of their rights.* Migrant domestic workers have become indispensable, stepping in where local labour and public care systems are unable to meet care demands. Though Malaysia aims to reduce reliance on migrant labour, many Malaysian families still depend on migrant domestic workers. Recognising the domestic care sector as an essential component of the care system is necessary to uphold the rights and wellbeing of migrant domestic workers.

8. *Recognise and address gendered dimensions of care* (and its undervaluation). Women continue to shoulder the majority of unpaid care work within households while also dominating paid care sectors. The association of care work with femininity, whether paid or unpaid, continues to contribute to the undervaluation of these sectors. Addressing these issues requires intentional governance measures that recognise the nature of care work, its inherent value and the importance of placing it at the centre of care policy design, implementation, and monitoring.

9. *Ensure inclusive stakeholder engagement.* The national coordinating entity must seek participation of non-governmental actors such as care workers, employers, unions, associations, volunteer bodies, and civil society organisations in policy dialogues and decision-making processes. This ensures care policies reflect lived realities.

Table 5 provides best practices from other countries, highlighting how national-level care coordination can be undertaken.

Conclusion

There is a clear imperative to invest in the care ecosystem. *As such, we believe investing at least 1% of GDP, or RM39.6 billion, into the care ecosystem is a crucial first step.* This investment could be one-off or year-on-year, as both have been demonstrated through economic modelling to yield returns. According to Onaran and Oyvat (2023), even a one-off investment of 1% GDP could offer returns of 2.2% GDP after five years. This means an investment of RM39.6 billion could potentially increase GDP by RM87 billion in five years.

Building ecosystem resilience is not only essential to supporting care workers, but also to ensuring that Malaysia can withstand future crises. As the country faces demographic change, public health risks, and increasing care demands, sustained investment in the care ecosystem is critical to safeguarding national wellbeing.

TABLE 5:

National-Level Care Coordination: Best Practices from Other Countries

Country	Policy Initiatives	Lead Ministry/Entity	How the care workforce features
Australia	The National Strategy for the Care and Support Economy 2023 is a whole-of-government plan to integrate aged care, disability care, early childhood care, and other sectors. Currently, a national roadmap and sector-specific action plans are being formulated in collaboration with state governments.	Department of Prime Minister & Cabinet (PM & C), through the Care and Support Economy Reform Unit (cross-ministerial collaboration).	The national strategy prioritises workforce strengthening and addressing workforce shortages by improving job security, ensuring fair wages, inclusive workplaces, clearer training pathways and professional recognition of care workers.
England	Since 2014, England has set out on a vision for better integrating health and social care. The Health and Social Care Act 2022 contains provisions for integrated care systems (ICS) and strengthened structural integration of the National Health Systems (NHS) and Social Care. Accompanying these reforms are policy initiatives to strengthen the care workforce. The most recent initiative for social care is the Adult Social Care Workforce Strategy 2024 which was updated in 2025. For healthcare, it is the NHS Long-Term Workforce Plan 2023. Both share a shift towards community-based integrated models of care.	Department of Health and Social Care, NHS England, ICS Partnerships. Leading the implementation of the social care workforce strategy is Skills for Care, with support from the Care Quality Commission (CQC), Oversight Executive Group, and other groups and bodies.	The NHS Long-Term Workforce Plan 2023 seeks to ensure the sustainable growth of the healthcare workforce for the next 15 years. It has identified the priority areas of 'train', 'retain' and 'reform'. Its main focus is to increase the size of the workforce, improve the retention of staff and improve productivity through innovative ways including through technology. Similarly, the Adult Social Care Workforce Strategy 2024 sets out the country's direction and plans to address social care workforce shortages (including through management of international recruitment). Its priority areas for the next 15 years are to 'attract and retain', 'train' and 'transform', recognising that reversing the decline in the social care workforce requires proactive measures.

Uruguay	***Sistema Nacional Integrado de Cuidados*** (SNIC) or the National Integrated Care System was established in 2015 to set up a co-responsible model of care. Its implementation is ongoing with the latest plan being the ***Plan Nacional de Cuidados 2021–2025***. Uruguay's integrated care system has been regarded as a regional model though it faces coverage and sustainability challenges. The plan also emphasises strengthening community/ territorial based care initiatives.	The National Board of Care is an inter-ministerial board responsible for defining guidelines, objectives and policies, and is advised by an Advisory Committee (AC) comprising 16 representatives of civil society organisations, academia, workers and the private sector. The National Care Secretariat (Secretaría Nacional de Cuidados) under the Ministry of Social Development (MIDES) coordinates activities across several ministries and reports to the National Board of Care.	The strategy focuses on making care work visible and valued, professionalising paid care roles, formalising informal caregivers, addressing gender and labour inequalities.
Singapore	Singapore positions care within the health and aging agenda. In 2015, Singapore launched the Action Plan for Successful Ageing, a national blueprint to integrate health, social, and community initiatives for aging. This plan was updated in 2023 and comprises over 70 initiatives across various domains. Childcare, disability care, and family support are not included in this plan, and are addressed through other initiatives. Active Aging Centres (AACs) are community-based care centres that serve as entry points for senior citizens to access the suite of integrated services.	The Singaporean Ministry of Health (MOH) oversees aged care, long term care and community care: • Ministerial Committee on Aging formed under MOH is an inter-ministerial coordinating body that oversees Singapore's aging and care strategy; • The Agency for Integrated Care (AIC), is a statutory body under MOH that leads coordination and supports the delivery of aged and community care services across health and social domains; Ministry of Social and Family Development (MSF) oversees childcare, disability services and family support.	Through accompanying policy documents and programmes, Singapore has made efforts towards strengthening the community care workforce, ensuring appropriate training and upskilling. For example, the SkillsFuture programs provides upskilling for healthcare and eldercare workers

Source: Australia (Department of the Prime Minister and Cabinet 2024), United Kingdom (NHS England 2023; Skills for Care 2024; The King's Fund 2022), Singapore (Ministry of Health Singapore 2023; Agency for Integrated Care 2025), Uruguay (UN Women 2019; UN Women 2023; Sternkopf 2024).

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