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Migration for care and care for migrants in East Asia: Challenges for social policy and long-term care reforms

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Introduction

This paper provides an overview of the recent policy development in long-term care for older people in East Asian societies and reflects on the challenges confronting care policy making in light of the global gender equality agenda and goals set out in the Millennium Development Goals, Sustainable Development Goals, and International Labour Organization's decent work framework. This paper showcases an example that social policy making needs to take into account the interlinkages between social protection, sustainable infrastructure and public services, and more specifically that long-term care reforms aiming at expanding public care services may lose sight of important gender inequality consequences. Building sustainable human resource infrastructure in the provision of public care services means considering welfare of the care-givers as well as the receivers. This however can often be hampered by immigration and social citizenship barriers. Care policy can only be truly transformative when the low status of care work or "women's labour" is redressed.

Care for older people, both in the household and as a domain of social policy, has long been known as a gendered issue. In East Asia, care responsibilities within the family are customarily assumed by women, and most care jobs are taken up by women, for example as domestic workers. ILO (2015) estimated that over 80% of the 24 million domestic workers in the Asia-Pacific region are women. Care is also highly associated with "feminized" migration in the region (Piper & Yamanaka, 2005), as governments turn to female migrant care workers[1] to fill care labour shortage against rapid demographic changes (Islam & Cojocaru, 2016). Within the 24 million domestic workers, for example, 14.1% are migrant workers—3.3 million migrant domestic workers and 2.7 million female migrant domestic workers (ILO, 2015). However, these figures only account for international migration and care work in private homes. The numbers would become significantly larger if China's internal migration and care work in institutions had been taken into account. China alone had over 13 million domestic workers in 2013, constituting about one-fifth of the total 67 million domestic workers in the world. The large majority of these Chinese domestic workers are internal rural-urban migrants (ILO, 2015; Li, 2008), 89.6% of whom are women (Wang, 2016).

Care is also intertwined with social protection for women in two ways. Firstly, care in itself may be considered a form of protection for people who have certain dependency and developmental needs. In elder care, older women are more likely to be service users. Secondly, care as a kind of service work also concerns with social protection for women working as care-givers. International migrant workers as care workers often face barriers to access to formal social protection, especially contributory social insurance, because of restrictions by immigration policies and poor portability of benefits (Faist, 2017; Pasadilla & Abella, 2012). When a care workforce primarily comprises domestic migrants, this problem can happen within, as much as across national borders.

[1] In this paper, migrant domestic worker and migrant care worker are used interchangeably, because domestic workers are primarily care providers in their jobs; and in many places like Singapore and Hong Kong, migrant care workers mostly work in private households.

The rest of this paper briefly lays out some of the social policy challenges for East Asian societies. Long-term care here primarily refers to social care in the form of assistance with basic activities of daily functions for older people in institutions and in private households. Most tasks involved in such care are often deemed low-skilled, yet they are almost always characterized by intimate human contact, long-term companionship, and emotional labour.

It should be noted that despite the shared culture around familial norms and care practices among East Asian societies, political dynamics and policy histories of the respective countries and territories are diverse. This paper will touch upon the cases of Japan, South Korea, China, the Taiwan Province, and Hong Kong SAR, and will discuss the case of China[2] to highlight the challenges in long-term care policy reforms in East Asia. Singapore will also be included in the analysis for its shared cultural and historical background with the aforementioned societies. Information reported here draws from research literature, policy documents, national survey data, and interviews with migrant workers and care manager in the care program in the city of Shanghai, China.

Long-term care reforms and migrant worker status in East Asia

While the family's responsibilities to care for senior family members are often reflected in national legislations, familial care provision has been greatly challenged by demographic shifts in East Asia, especially population aging, changing family structure, and increased women's labour participation, resulting in an elder care "crisis" that calls for reforms in the care sector.

In the past three decades, governments in East Asia adopted an array of policy strategies to provide needed care for older people. A common thread was these measures' capitalizing on the readily available migrant labour sources: for China, its internal migrants and for the rest, international migrant labour secured primarily through bilateral EPAs with South-East Asian countries, the Philippines, Indonesia, and Vietnam for example.

The following section provides an update on the various paths taken by the East Asian societies in tackling the elder care crisis. It also serves as an analysis of how state regulation of care provision coupled with immigration policies can result in different conditions of care work and affect social status of and protection for care workers. To organize the following discussion around a simplified analytic framework which encompasses all the societies under examination, two main factors are considered here.

1) Migrant worker mobility

Firstly, it can be observed that in East Asian societies, migrant workers are introduced into the care sector through different immigration channels and that they enjoy different levels of freedom of movement. At one end, migrant workers may only enter care-related jobs through

[2] More specifically the case of Shanghai, which serves as one of the largest national pilot sites in the Chinese long-term care reform.

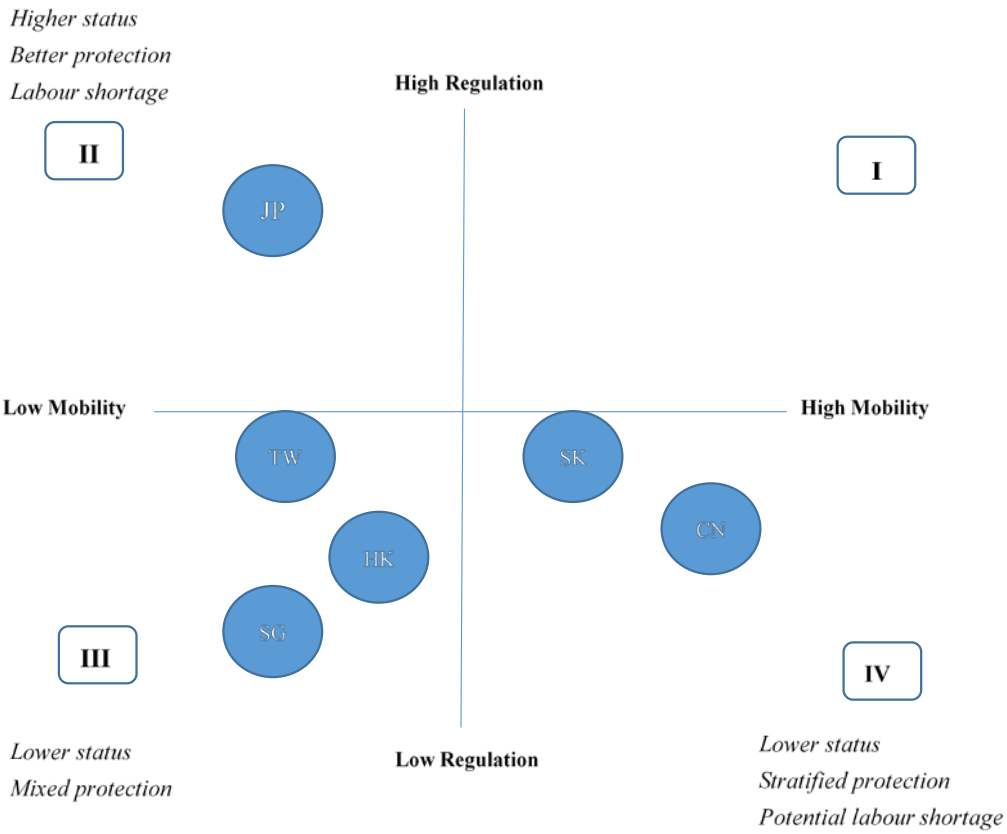
dedicated immigration channels such as EPAs or work under short-term, defined contracts governed by general immigration laws. They are not free to move between jobs, and their immigration status is almost exclusively tied to the position or contract of care work. At the other end is more relaxed admission of migrant workers, who upon entering can freely move between a broader range of occupations. They are allowed to change jobs without losing status. Their visa/ residency validity periods are usually longer or unlimited.

2) Degree of regulation in care service provision

Secondly, the extent to which care services are regulated is of relevance. At one extreme is the highly market-oriented, deregulated model (Peng, 2017). Private for-profit service providers bring into the care sector the logic of competition and cost containment. Care workers may not be required to demonstrate experience or qualification specific to care work. On the opposite side is the highly regulated model. Service providers are predominantly, if not exclusively, publicly owned, financed or subsidized. Participating private non-for-profit bodies behave like their public counterparts. Training and certification are mandatory for care jobs.

Intersecting these two factors yields four quadrants representing different reform paths, in which migrant care workers may fare differently in terms of their status and social protection (see Figure 1 below). The following discussion starts with quadrant II.

Figure 1 Migrant worker mobility and regulation of care provision



*JP: Japan, SK: South Korea, SG: Singapore, CN: China, TW: The Taiwan Province, HK: Hong Kong SAR

Quadrant II: Higher regulation, lower mobility, higher status, better protection, but labour shortage

In quadrant II, designated immigration channels for care jobs are combined with highly regulated care services. Japan falls in this quadrant. Japan began to consider a comprehensive strategy since the 1980s and introduced a universal Long-Term Care Insurance (LTCI) system in 2000. The Japanese system is highly regulated in that it only provides in-kind benefits and includes certified service providers under government-set fee scales and supervision. All care professionals must go through a stringent training and certification program. Policymakers also made efforts to subsidize wage and improve work conditions in order to attract young people and other employable groups to care work (Song, 2015). In the meantime, the Japanese system sparingly employs migrant workers from EPA partner countries through a skilled worker class. Migrant care workers must pass the same certification test and a language proficiency test, after which they are allowed to work only in care institutions but not private households. While the Japanese model repels migrant care workers, one of the consequences is that care work is a decent job, if not of high status, and the small number of migrant care workers can be reasonably valued in this occupation as skilled workers. In jobs created directly by LTCI and publicly funded programs, migrant care workers tend to be treated on par with native workers[3]. Challenges associated with this model is significant care labour shortage and high cost of the system. Under this pressure, the Japanese system now works to bring in more migrant workers.

Quadrant III: Lower regulation, lower mobility, lower status, mixed protection

In quadrant III, designated immigration categories meet a free market of care, and governments are minimally involved in regulating care provision. Singapore and Hong Kong fall in this quadrant. Both governments resort to migrant care workers as a means of support to familial care by lowering levies for hiring migrant care workers in private households. Elder care jobs almost always come available to migrant workers as contract-based live-in domestic work. Terms of a contract are negotiated directly between the employer and employee. Care is a recognized type of work, but it is unskilled and suitable only for foreign migrant workers.

Generally speaking, this kind of employment ties a migrant worker to the employer, creating serious power imbalance and potential exploitation behind closed doors. For example, employers may undercut wages and violate original contracts. Immigration and labour protection policies may work to counterbalance or reinforce this problem. In Singapore, migrant care workers are governed by the Employment of Foreign Manpower Act for migrant workers, which offers limited labour protection (Koh et al., 2017). Upon entering Singapore, work contracts are negotiated directly between the employee and the employer or through a representative agency. Care workers are not allowed to change employer mid-way through a

[3] Migrant workers may still be disadvantaged when they are employed as interns in institutions and denied of equal status as a full-time care worker.

contract, and they have to leave the country in the case of contract discontinuity. Female workers are screened for pregnancy every six months, and if found pregnant they would have to leave the country for birth giving. Similarly, a female migrant care worker cannot legally marry a local man unless they go outside of the country. In addition, migrant domestic workers hold a special kind of visa that precludes permanent settlement. These policies render female migrant workers more vulnerable to exploitation.

In Hong Kong, migrant domestic workers are covered by the Employment Ordinance, which regulates all employment relations. This means that migrant domestic workers are treated equally with native employees in terms of basic entitlement and welfare, such as rest day, holidays, leave, health and occupational injury insurance, and limit of salary deductions. Labour contracts are standardized, allowing limited leeway for employers to interpret or alter contracts to their own advantage (Wang et al., 2018). In addition, Hong Kong's immigration policy is more lenient in the case of contract discontinuity and marriage for migrant workers, who get a grace-period for seeking a new contract and are allowed to settle through marriage. It may be argued that migrant workers in Hong Kong fare relatively better and enjoy greater mobility and settlement opportunities.

Between Quadrant III and II stands the Taiwan Province, where intense political debates around institutional design of the care system and prolonged legislation processes are still unfolding. On the one hand, it opened its care sector to migrant workers as early as 1992 by allowing migrant workers from EPA countries to work in designated care job categories (Peng, 2018). Like Singapore, local labour laws do not cover migrant domestic workers, although the Labor Standard Act does cover other migrant worker categories. Care work in private homes are deemed "different in nature" and therefore left with room for on-site negotiation (Chien, 2018). On the other hand, attempts to regulate the care sector has seen some recent progress. Governed under the Long-Term Care Service Act passed in 2017, care workers in long-term care facilities are now required to complete licensing training and certification (Peng, 2018). Together with the Long-Term Care Insurance Act under review, this could translate into that migrant care workers in care facilities will be recognized and treated equally with native workers in terms of wages and labour protection. Although this group only constitutes 6% of the total 245,000 migrant care workers in the region, the recent policy development puts it closer to quadrant II compared to Singapore and Hong Kong.

Quadrant IV: Lower regulation, higher mobility, lower status, stratified protection, and potential labour shortage

In quadrant IV, migrant workers can move freely between jobs and in and out of the care sector, but service provision is only partially or not regulated. South Korea falls in quadrant IV. Its 2008 LTCI system was primarily modeled on the Japanese version, with the exception that it also provides an in-cash family care allowance, which benefits 35% of its recipients (Peng & Yeandle, 2017). The new Korean system initially came together with the purpose of promoting employment among low-income Korean women. However, the less stringent training and qualification test rapidly created a large cohort of certified native workers but failed to retain them because of unsatisfactory work conditions and low pay (Song, 2015). In order to roll out

the program without significantly inflating public expenditure, private service providers were introduced, thus a competition mechanism too. With the quick expansion of the service delivery system, care quality was compromised (Rhee et al., 2015). Under the pressure of labour shortage, Korean policymakers further permitted admission of co-ethnic Chinese Korean migrant workers into the LTCI financed positions. However, because the co-ethnic migrant workers, who hold a special work visa of 5-year validity period, could also be more conveniently hired by private households irrespective of LTCI benefits, most co-ethnic migrant workers in the care sector are now employed directly by the households at lower wage and more relaxed labour regulations (Peng, 2017). Although the Korean model is often considered similar to Japan's model, a clear dual-market of care is created in the Korean system (Peng, 2018). Social protection for migrant workers is therefore stratified in the two markets of care. A large proportion of migrant care workers are employed in the "grey" care market, where their labour is viewed a natural extension of the uncompensated care traditionally performed by female family members and as a result excluded from legal labour protection (Piper & Yamanaka, 2005). Although co-ethnic migrant workers can freely move between jobs, these jobs are all so-called "3-D" jobs, dirty, difficult, and dangerous (Song, 2015). Associating care with the migrant worker group places the "3-D" social label on care work and does not help lift its low social status and work conditions.

China too can be placed under quadrant IV. However, the fact that Chinese care policy makers do not have the immigration measures at hand, that is they cannot create a designated immigration category for care workers, means that they must address the care crisis in a more comprehensive way, especially considering the interlinkages between promoting public services, developing sustainable human infrastructure, and ensuring social protection for domestic migrant workers. Thus, the care policy challenges are arguably more salient in the Chinese case.

China began to see changes in its landscape of the care sector in the late 1980s. In richer urban regions, hiring live-in maids or nannies became viable when restrictions on internal migration had been relaxed and supply of rural migrant workers released. On the public front, the central government called for "socialization of care" in a framework document issued in 2000, recognizing need for a care reform in the face of Chinese family's reduced ability to provide care. Typical government strategies included subsidies for capital investments in building care facilities, consolidating domestic service brokers, mandating job training, and initiating financial support schemes to reduce older people's out-of-pocket spending for care services. The most recent development featured a national pilot of LTCI programs involving 15 cities. Shanghai was one of the earliest and largest pilot sites and is currently financed through the public health insurance and taxation. The scheme covers both home-based and institutional care services offered by certified providers and care workers. While official data about the size and composition are unavailable, the workforce comprises at least 80% migrant workers, while the 20% local workers are mostly urban laid off employees recruited through re-employment programs[4].

[4] The numbers are based on the author's own research (Hong, 2017).

Like the Korean case, in order to quickly expand public care services, a convenient solution for China is to turn to private service providers and migrant care workers. The more developed economy and higher wage in urban areas continue to attract migrant workers from rural areas. Job training and certification at the entry level are of lower standards and difficulty. Care work is primarily associated with the social identity of internal rural-urban migrant workers, who are viewed as uneducated and second-class in the cities (Hong, 2017).

In theory, China's social insurance system has achieved wide coverage for rural-urban migrant workers, who should be by default covered by rural schemes at their *hukou* or residence origin. Urban social insurance programs, especially health programs, have in recent years developed to be more inclusive and cover rural-urban migrants employed in the cities. However, in practice, migrant workers' enrolment in urban plans is still quite low. Based on a 2015 national survey, only 30.1% of all Chinese migrant workers[5] are enrolled in urban health insurance plans (Wang, 2016). In addition, the type of employment characterizing care work--in small businesses, through labour dispatching, or in private household--is considered informal sector employment, in which social protection enrolment is often subject to discretion of and negotiation between the employer and employee. Employees in the informal sector have 46.7% and 57.7% enrolment rates in pension and health programs respectively, compared to the higher than 90% enrolment rates for employees in the formal sector (Jiang et al., 2018). The combined effect of migration and informal employment renders female migrant care workers more vulnerable. Migrant workers employed in the informal sector have much lower enrolment rates in all programs of social insurance, while female workers' enrollment is even lower than male workers. For example, female migrant workers' enrolment rates in pension and heath programs were 6.7% and 14.6% respectively, compared to men's 7.6% and 16.8% (Yuan, 2015). While job-specific data are not yet available[6], it can be inferred from the existing knowledge of gender segregation in the service industry that female care workers are among the most disadvantaged groups in terms of social protection.

The reasons for the low social protection coverage rates for migrant care workers can be understood at two levels. At micro level, the high drop-out rate can be attributed to the reason that migrant care workers have inadequate knowledge about the social insurance system in general or for the specific city they move into. To reduce labour cost, employers are ready to take advantage of care workers' unfamiliarity with the systems and find ways to avoid paying their share of insurance contributions. When migrant workers do have knowledge about the system, voluntary drop-out is prevalent because migrant workers are sensitive to the immediate spending on insurance premium.

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[5] Including both urban-urban and rural-urban migrants, with the latter taking up approximately 84% of the total (Wang, 2016).

[6] With the recent inclusion of more specific categories of care work in the national occupation classification, more accurate estimation should be possible with future government statistics and survey data.

On the institutional level, portability of entitlements based on long-term continuous contribution, such as pension benefits, is particularly difficult to achieve (Taha et al., 2015). China's social insurance system is geographically fragmented. Insurance schemes are pooled and offered at prefectural and municipal levels, subject to local conditions and constrained by local governments' financing capacity (He & Wu, 2017). Multiple schemes are available across rural and urban regions. Rural-urban migrant workers can easily fall between the cracks as they transfer between schemes, jobs, or locations.

Differential treatment of migrant and local workers in the same care program also creates stratified social protection statuses of employees within the LTCI system. When enforcing social insurance coverage and labour standards in the care sector, urban governments are found to prioritize local residents over migrant workers (Hong, 2017), which contributed to some public care institutions' difficulty in retaining migrant workers, in particular those who are younger and have higher levels of education. If this situation continues, it may be predicted that public care services will face greater labour shortage problems in the future.

Conclusions

The care reforms in East Asian may be understood as a transition from a "family model of care" to a "migrant in the family" or a "migrant in agencies" model of care (Bettio et al., 2006; van Hooren, 2012). These reforms reflected "constructed segmentation of occupations linked to social categories" (Findlay et al., 1998). The use of migrant labour in care work requires social boundaries to be formed along the lines of nationality, gender, ethnicity, and citizenship entitlements. Currently, no case can be placed under quadrant I. In quadrant II, care work is of relatively higher status; care workers are better protected. Yet a serious labour shortage problem exists. In quadrant III, supply of care labour is abundant, but care workers may face the most adverse conditions. In quadrant IV, care is primarily provided by co-ethnic migrant workers who are deeply involved in the destination society but are not fully accepted and integrated into the society. A second-class citizenship is created, and care work is associated with it. In the long run, labour shortage may also be a concern.

In responding to the care crisis, an incremental approach to policymaking is often adopted by policy makers, which relies on programs and infrastructure readily available and small adjustments to relieve public anxiety about most immediate social problems. Policy makers are pressured to promptly expand care services without imposing sudden and dramatic burden on government budgets or the already encumbered health care insurance system. However, it is clear that care costs are shifted to migrant workers, which in turn perpetuates gender inequalities in social protection and work conditions. In particular, unlike its neighbours, China cannot create an isolated space exempt from labour protection through immigration programs; nor could it afford to reinforce the othering effect that widens the divide between rural and urban residents. The real challenge for the care reform is thus more compelling: to build a care system in which care workers are reasonably protected and treated equally. This means that 1) the social protection system should cease to single out migrant workers, and entitlement to social protection should cease to function as an identity marker; 2) training and certification for care jobs should be seen as investments in building sustainable

human resource infrastructure, which explicitly addresses gendered occupational segregation; and 3) service jobs generated through care reforms should set a standard of higher quality and status, so that care work can be further legitimized, treated as a decent job, and recognized as a social good.

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