JOBS BOOM FOR FILIPINO HEALTH CARE ASSISTANCE WORKERS

ISSUE NO. 3 | SERIES OF 2018

LABOR MARKET INTELLIGENCE REPORT

Technical Education and Skills Development Authority

December 2018

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Labor Market Intelligence Report

Executive Summary

The current global trend in health necessitates the creation of job opportunities all over the world. More and more developed countries have acknowledged the importance of the provision of quality and affordable, if not free, health care and are devising ways on how they could make these services accessible to their people.

Australia has created the National Disability Insurance Scheme (NDIS) to provide "reasonable and necessary" support for its citizens aged under 65 with a permanent and significant disability. Once the NDIS is fully implemented, it will require 300,000-plus new full and part-time jobs by the time it is meant to be fully operational in 2020.

Japan's National Health Insurance (NHI) provides universal access to its citizens through a network of more than 4,000 public and private payers.

United States of America is implementing its health care assistance programs namely— Medicare and Medicaid. *Medicare* is a federal program that provides health coverage if you are 65 and older or have a severe disability, no matter your income. On the other hand, *Medicaid* is a state and federal program that provides health coverage if you have a very low income.

Health Care is established as the leading industry in employment in both the Australia and the US while Japan is the top country in terms of aging population. The health care and assistance industry in these countries are currently facing challenges with perceptions of widespread and increasing workforce shortages. Examples of hard-to-fill jobs identified in the industry are *home health aides* and *personal care aides,* most commonly known as caregivers.

This paper will explore the possibilities of employment for Filipino workers. To address foreseen issues that may hinder Filipino workers to avail this employment opportunities, the following actions are recommended:

1. Bilateral discussions should be initiated between countries if none exist as this will help in better employment facilitation of caregivers from the Philippines.

2. It is only expected that these countries will require its future health assistants to comply with their respective qualification requirements. With this, TESDA should guarantee its training regulations to be at par with their industry requirements.

3. Another critical requirement is the certification of Filipino workers. Recognition on the certification that the Philippine government will issue to its workers should also be established or worked with the receiving country to ensure holders of these certificates have the necessary requirements to be employed.

4. For TESDA, depending on the actual demands from receiving countries, the Training for Work Scholarship Program (TWSP) could be adjusted. Should there be a lack of workforce supply, scholarship allocations could be refocused to Caregiving NC II.

5. Furthermore, it is also important that the issues discussed in this report (highly casualized workforce, underemployment, occupational health and safety challenges, etc.) also be discussed during meetings with concerned Philippine government agencies to ensure that decent and just jobs will be given to overseas Filipino workers.

The paper also delves at the necessary arrangements to be made between the governments in the hopes of bridging the gap in the demand and supply of health care assistants in Australia, Japan and the United States.

I. Defining Health care and Assistance

Health care is different from other goods and services: the health care product is ill-defined, the outcome of care is uncertain, large segments of the industry are dominated by nonprofit providers, and sometimes (or most of the time for some countries) payments are made by third parties such as the government and private insurers. Many of these factors are present in other industries as well, but in no other industry are they all present. It is the interaction of these factors that tends to make health care unique. (Morrisey, 2018)

Health assistants is defined as those who provide assistance and support to health professionals by whom they are directly or indirectly supervised (Munn , Tufanaru, & Aromataris, 2013). Health assistants can have varied roles, and may work within professions or across them.

On the other hand, *home health aides* and *personal care aides* provides individual assistance to those who need help looking after themselves, such as those recovering from an illness, such as a stroke. The primary distinction between the two is that the former requires providing basic health-related care services (such as taking vitals or assisting with medical equipment, such as oxygen bottles) while the latter is purely a caregiver or personal attendant role providing non-medical assistance, such as preparing meals or driving the patient.

II. Health care and Social Assistance as the Largest Employer

For the job market, there can be no overstating when it comes to the number of opportunities it may hold. As economies grow, employment follows. This allows the employment landscape for each country to vary. While some countries are struggling in producing employment opportunities for their constituents; some are facing another type of problem—the lack of skilled workers to fill already available jobs.

According to Frost & Sullivan, despite ongoing political uncertainties and rising cost pressures, the global health care industry will register a stable growth rate during 2018, and it will cross the $1.85 trillion mark in terms of manufactures' revenues. (Das, 2017)

According to the Australian Bureau of Statistics' latest media release on the sector, the Health Care and Social Assistance industry was Australia's largest industry by employment in the 2016 Census of Population and Housing. The industry, spanning sectors such as hospitals, and aged and child care, grew by around 16 per cent. The industry now accounts for 12.6

per cent of Australia's working population, increasing from 11.6 per cent in 2011 and 10.5 per cent in 2006 (Australian Bureau of Statistics, 2018).

Table 1: Employed persons - by Industry (Australia, 2016)

INDUSTRY	2016	2011	Growth (%)
Health Care and Social Assistance	1,351,015	1,167,633	15.7%
Retail Trade	1,053,816	1,057,309	-0.3%
Education and Training	925,895	804,419	15.1%
Construction	911,056	828,910	9.9%
Professional, Scientific and Technical Services	775,978	730,062	6.3%
Accommodation and Food Services	738,231	650,396	13.5%
Public Administration and Safety	713,135	689,929	3.4%
Manufacturing	683,688	902,829	-24.3%
Transport, Postal and Warehousing	499,491	479,181	4.2%
Financial and Insurance Services	384,608	377,352	1.9%
Administrative and Support Services	365,731	323,779	13.0%
Wholesale Trade	307,741	403,800	-23.8%
Agriculture, Forestry and Fishing	266,946	249,827	6.9%
Rental, Hiring and Real Estate Services	182,151	158,853	14.7%
Information Media and Telecommunications	179,521	178,190	0.7%
Mining	177,647	176,560	0.6%
Arts and Recreation Services	176,667	151,575	16.6%
Electricity, Gas, Water and Waste Services	115,753	115,608	0.1%
Other Services	399,635	378,217	5.7%
*Other Services includes Repair and Maintenance, Personal Care and Religious Services			

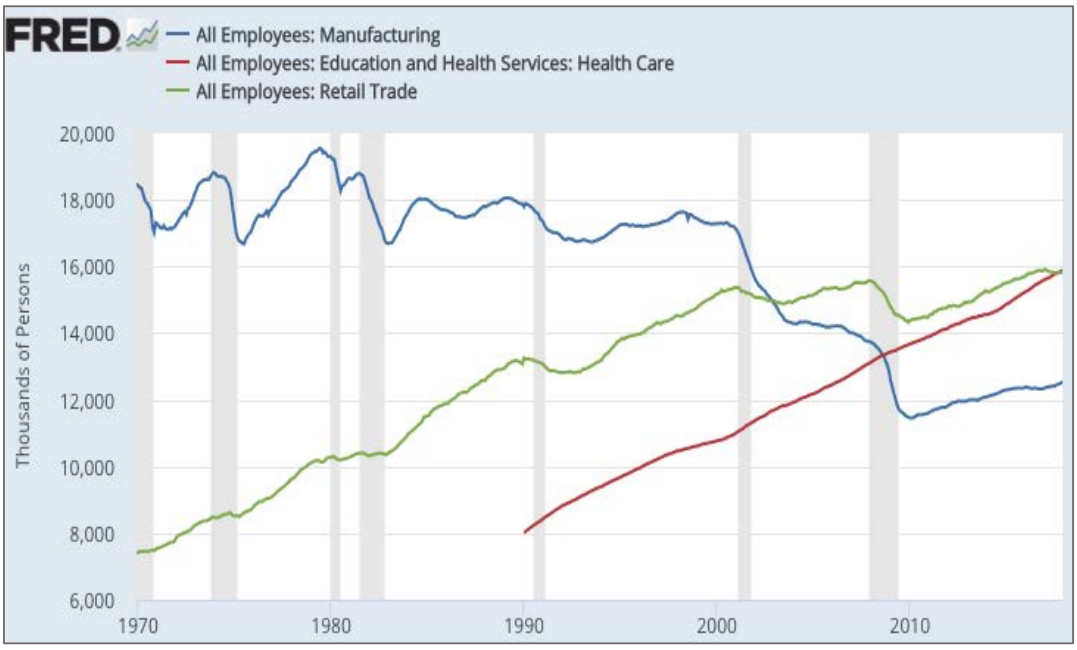
Source: Australian Bureau of Statistics

Over the past decade, continuous growth is seen in the industry as it quietly became entrenched as Australia's biggest employer.

The same thing is happening in the United States. According to the Atlantic, health care just became the U.S.'s largest employer as of the last quarter of 2017. (Thompson, 2018)

In 2000, there were 7 million more workers in manufacturing than in health care. At the beginning of the Great Recession, there were 2.4 million more workers in retail than health care. In 2017, health care surpassed both.

Figure 1: Number of Workers in the Top Industries in the US



Source: Federal Reserve Economic Data, St. Louis Federal Reserve System

In Japan, the birth rate has been falling and the number of elderly people has been growing. This requires its social security to address various changes in the socioeconomic environment.

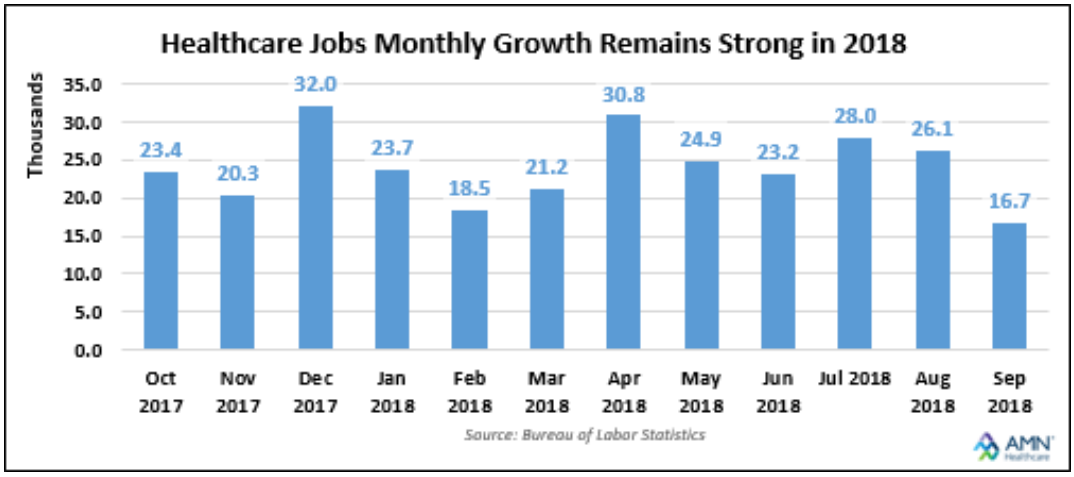
Japan has a universal health insurance regime to ensure that anyone can receive necessary medical treatment. Under this regime, every citizen enters a publicly regulated medical insurance system, such as employees' health insurance or national health insurance.

This medical care system has contributed to Japan's achieving the highest life expectancy in the world, as well as a high standard of healthcare along with improvements in the living environment and better nutrition. Life expectancy at birth was 87.1 years for women and 80.8 years for men in 2015. Japan's life expectancy remains the highest level in the world. (Statistics Bureau, Ministry of Internal Affairs and Communications Japan, 2017)

However, longer life expectancy leads to an increasing demand for life-prolonging health care.

In the US, the recent growth in health-care employment is stemming more from administrative jobs than physician jobs. The number of non-doctor workers in the health industry has exploded in the last two decades.

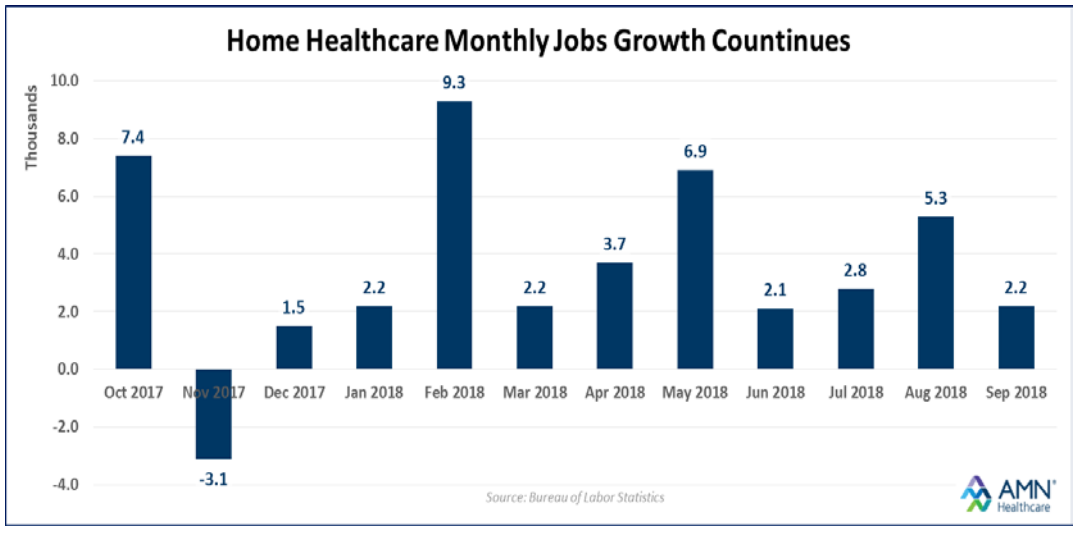
Figure 2: Health care Jobs Monthly Growth in the US



Source: Health care Workforce Data, 2018

Of the 10 jobs that the Bureau of Labor Statistics projects will see the fastest percent growth in the next decade, five are in health care and elderly assistance. The two fastest-growing occupations—personal-care aides (who perform non-medical duties for older Americans, such as bathing) and home-health aides, (who help the elderly with medical care)—are projected to account for one in every 10 new jobs in that time. The entire health-care sector is projected to account for a third of all new employment. (Thompson, 2018)

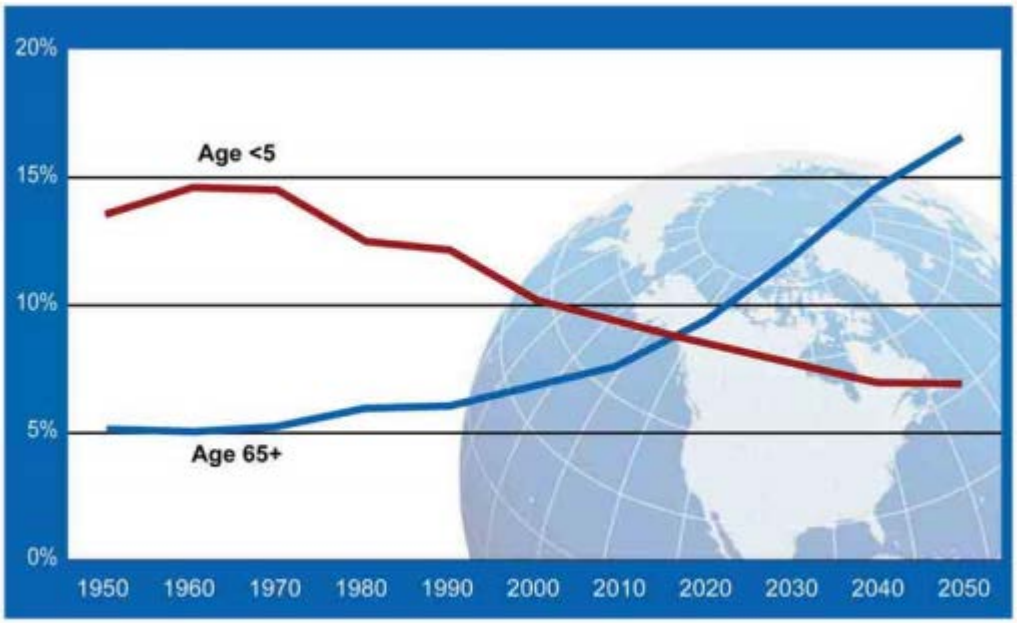
Figure 3: Home Health care Monthly Jobs Growth in the US



Source: Health care Workforce Data, 2018

According to the Federal Health Resources and Services Administration (HRSA), 3.4 million direct care workers will be needed by 2030, with one half of the demand for home or community-based care, one quarter for residential care facilities, and one quarter for nursing homes. (Formaspace, 2018)

Figure 4: Young Children and Older People as a Percentage of Global



Source: United Nations. World Population Prospects: The 2010 Revision. Available at: http://esa.un.org/unpd/wpp.

The current trends in the health workforce market is influenced by a wide range of factors, which include, among others, the changing disease profiles and focus on the prevention of chronic disease (Segal & Bolton, 2009).

One major factor in this care boom is increasing levels of income and wealth especially in developed countries. It is hardly surprising that as people become richer, they become more prepared to spend more on health and wellbeing.

In addition to this, the relentless advance of medical sciences has resulted in the emergence of new technologies, new products, services and treatments. People have become more and more willing to spend money in exchange for quality health care and assistance.

Another factor is the ageing of the population underpinning the care boom because older people tend to consume more health care and social assistance services (Australian Bureau of Statistics, 2018). This is especially true since the advancement of medical sciences almost often results to extended human life span.

According to the Global Health and Aging report presented by the World Health Organization (WHO), "The number of people aged 65 or older is projected to grow from an estimated 524 million in 2010 to nearly 1.5 billion in 2050, with most of the increase in developing countries." In addition, by 2050, the number of people 65 years or older is expected to significantly

outnumber children younger than 5 years of age. (World Health Organization, 2011) This means that the demand for elderly care isn't a unique feature of the above-mentioned developed countries, but is also a general trend on a global scale.

Globalization and automation, the two most destabilizing forces for labor also has an effect to this. Together, they have hurt manufacturing and retail (the two previously leading industries in creating jobs) by offshoring factories, replacing human arms with robotic limbs, and dooming fusty department stores. But health care is substantially resistant to both. While globalization has revolutionized supply chains and created a global market for manufacturing labor, most health care remains local. (Thompson, 2018)

Subsidizing health care also fuels the continuously increasing demand for workers. Governments are spending considerable amounts of money on health-care benefits each year. This public support makes health-care employment practically invincible, even during the worst downturns.

III. Country Efforts: Incentivizing the Health Care Industry

A. Australian National Disability Insurance Scheme (NDIS)

The National Disability Insurance Scheme (NDIS) provides support to people with disability, their families and carers. It is jointly governed and funded by the Australian and participating state and territory governments. The NDIS was introduced across Australia on July 2016, except in Western Australia where a 'nationally consistent' but state operated NDIS was introduced on July 2017. It is intended to help people with significant and permanent disabilities and who needs assistance with everyday activities (Buckmaster, 2017).

According to the Parliament of Australia's website, the NDIS was created to provide "reasonable and necessary" support for Australians aged under 65 with a permanent and significant disability. The main component of the NDIS is individualized packages of support to eligible people with disability.

The scheme is underpinned by an insurance model and each individual seeking access is assessed according to a common set of criteria. Individuals who are deemed eligible receive a package of funding to purchase the supports identified in their individualized plan. Because of the fundamental change to service provision, the NDIS was rolled out in stages, starting in trial sites from July 2013 before transitioning to full scheme implementation (Disability Support Services, 2016).

According to the National Disability Insurance Scheme Act 2013, access to the NDIS is determined by three separate and distinct legal requirements:

- the age requirements;
- the residence requirements; and
- the disability requirements or early intervention requirements.

These requirements are referred to as the NDIS access criteria, which should be met by the individual to be able to obtain access to NDIS.

The NDIS will take an 'insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability'. The NDIS Act also specifies that, "in implementing the NDIS, regard must be had to ensuring its financial stability" (Buckmaster, 2017).

When the NDIS is fully implemented, it is expected that around 460,000 Australians will receive individualized supports. The NDIS also has a broader role in helping people with disability to:

- access mainstream services, such as health, housing and education
- access community services, such as sports clubs and libraries
- maintain informal supports, such as family and friends, and
- receive reasonable and necessary funded supports

The NDIS will inject US$22 billion a year into the economy and will have a far greater impact on the economy: once fully implemented, it will require 300,000-plus new full and part-time jobs by the time it is meant to be fully operational in 2020 (Creighton, 2017). With the addition of NDIS' continuous injection of funds in the sector, the demand for health care and support services will continue to rise.

B. Japan's National Health Insurance (NHI)

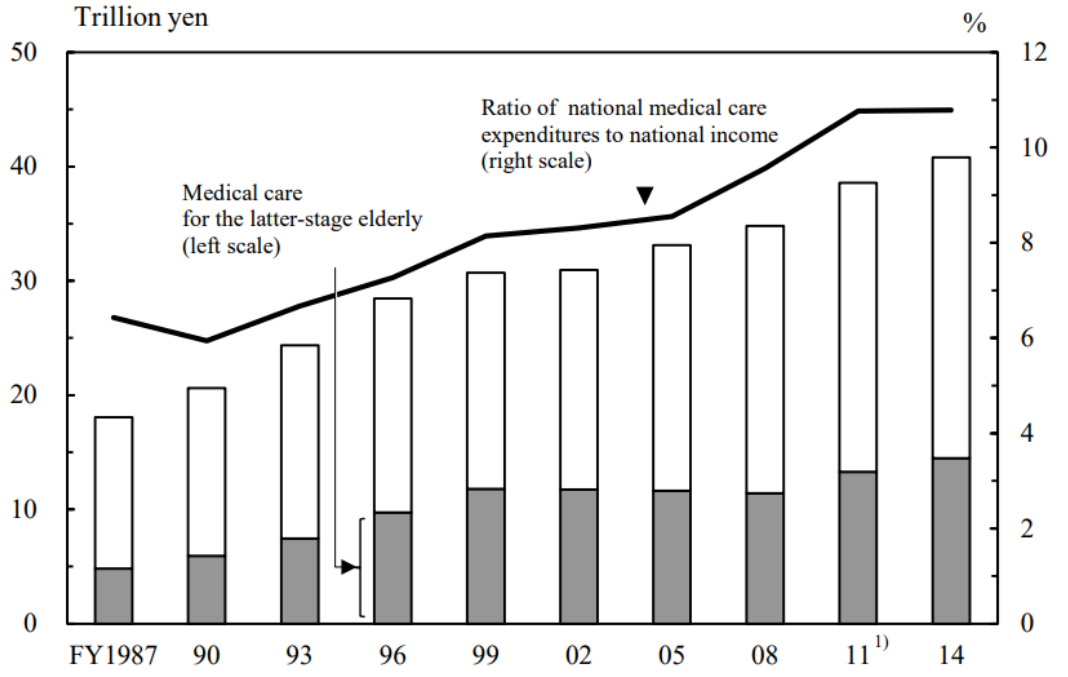
Japan's National Health Insurance (NHI) provides universal access to its citizens through a network of more than 4,000 public and private payers. It is a requirement for Japanese citizens to have health insurance, which covers a wide array of services, including many that most other health systems don't (for example, some treatments, such as medicines for colds, that are not medically necessary).

One of the major problems to this unique system of healthcare is its sustainability. The system imposes virtually no controls over access to treatment. There is no gatekeeper: patients are free to consult any provider—primary care or specialist—at any time, without proof of medical necessity and with full insurance coverage. Similarly, Japan places few

controls over the supply of care. Physicians may practice wherever they choose, in any area of medicine, and are reimbursed on a fee-for-service basis. There is also no central control over the country's hospitals, which are mostly privately owned. There is also a gap in the supply and demand for health care workers, due to the aging population.

These characteristics are important reasons for Japan's difficulty in funding its system, keeping supply and demand in check, and providing quality care. (Henke, Kadonaga, & Kanzler, 2009)

Figure 5: Japan Trends in Medical Care Expenditures



1) Excluding medical care expenditures pertaining to the Great East Japan Earthquake (4.5 billion yen in total, combining the payment for estimated billing and the medical care expenditures of unidentified insurers).

Source: Japan Ministry of Health, Labour and Welfare

Japan's health care system is becoming more expensive. The national medical care expenditures have been increasing gradually. In fiscal 2014, the expenditures totaled 40.8 trillion yen or 11.20 percent of Japan's national income. The cost of medical care per person averaged 321,100 yen in fiscal 2014. Currently, reform of the whole system is being undertaken in order to preserve the stability of this medical insurance system in the future.

True, the current cost—low by international standards—is projected to grow only to levels that the United States and some European countries have already reached. Yet funding the system is nonetheless a challenge, for Japan has by far the highest debt burden in the Organisation for

Economic Co-Operation and Development (OECD), a rapidly aging population, and a stagnating economy. (Henke, Kadonaga, & Kanzler, 2009)

C. American Health Assistance

In the US, both the federal and state governments are a major health care spender. Together they account for 46 percent of national health care expenditures; nearly three-quarters of this is attributable to Medicare and Medicaid. Private health insurance pays for more than 35 percent of spending, and out-of-pocket consumer expenditures account for another 14 percent. (Morrisey, 2018)

One of its major health care assistance programs is the infamous Medicare. This is a federal tax-subsidy program that provides health insurance for some forty million persons aged sixty-five and older in the United States. Medicare Part A, which provides hospital and limited nursing home care, is funded by payroll taxes imposed on both employees and employers. Part B covers physician services. Beneficiaries pay 25 percent of these costs through a monthly premium; the other 75 percent of Part B costs is paid from general tax revenues. Part C, now called "Medicare-Advantage," allows beneficiaries to join Medicare-managed care plans. These plans are paid from Part A and Part B revenues. Part D is the new Medicare prescription drug program enacted in 2003 but not fully implemented until 2006. (Morrisey, 2018)

Medicare is also available to low-income families and to children with certain disabilities and to dependent adult children whose parents are currently receiving Medicare. Below are the qualifications required of children with disabilities in order to qualify:

- Children with amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and end-stage renal disease (ESRD or kidney failure) can qualify for Medicare coverage soon after they have been determined to have a permanent disability.
- Dependent adult children who developed a permanent and severe disability before the age of 22 and whose parents currently receive Medicare are eligible to also receive Medicare benefits. A two-year waiting period for these benefits begins when the child turns 18 years of age. If the parent receiving Medicare benefits dies, the child will continue to receive benefits.

Another program is the Medicaid and Supplemental Security Income (SSI). Many children enter the Medicaid system through the Supplemental Security Income Program. In most states, children receiving SSI

automatically qualify for Medicaid, yet enrollment into Medicaid is not always automatic.

Medicaid covers a diverse range of conditions that many health care plans, such as an employer-paid plan, have typically not covered. In addition to providing traditional medical care, such as doctor's visits, Medicaid also covers the following:

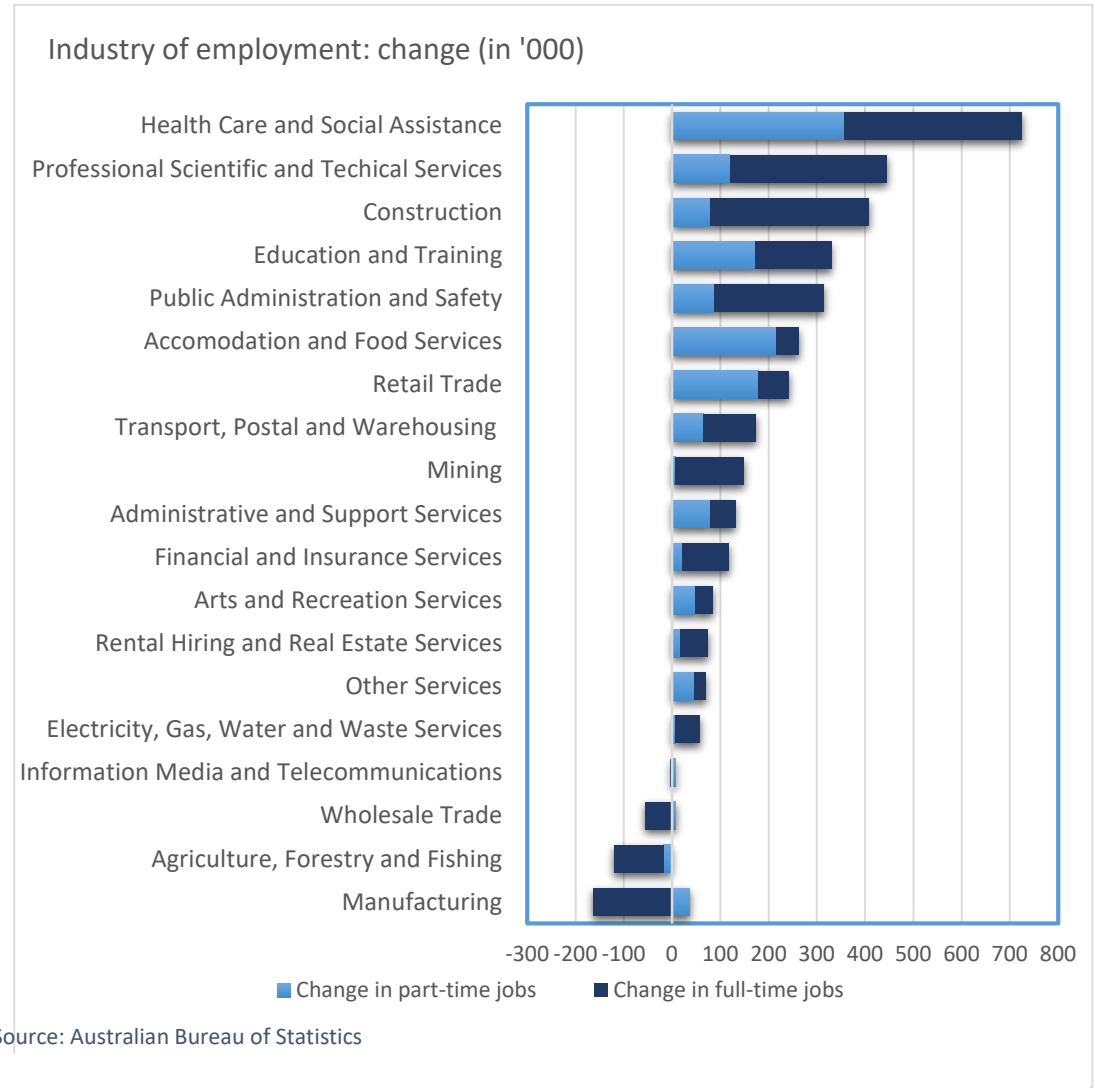
- Inpatient and outpatient hospital services
- Dental and vision care; depends on the state—fewer states are offering this type of coverage
- Laboratory and x-ray services
- Early screening
- Transportation and translation services
- Long-term care; includes home- and community-based services (HCBS) and acute (emergency room) care
- Each state has the option of providing additional health care services, such as personal care, prescription drugs, and rehabilitation services.

IV. Employment Projections

For Australia, its health workforce is currently facing challenges and is the subject of intense public interest. This is driven by the concern of policy-makers on the impact of 'population ageing' upon the supply of and demand for health professionals. With perceptions of widespread and increasing workforce shortages, the inevitable impacts on patient care are being exposed (Segal & Bolton, 2009).

Health care and social assistance is the fastest growing employment sector in the Australian economy and has been for the whole of the 21st century. Five million baby boomers are pushing into their 60s in their lifecycle.

Figure 6: Australian Job Growth in the 21st Century from Feb 2000 to Feb 2017



Source: Australian Bureau of Statistics

The US$22 billion tax payer-funded NDIS of Australia was responsible for as many as 52,000 of the new jobs created in 2017 (The Australian, 2018). As shown in the graph above, the bulk of new jobs created refers to health and social assistance jobs. Specifically, up to 13% of the 400,000 jobs created last year involved specialist health care and caregiver roles according to analysis by economists at Goldman Sachs (The Australian, 2018).

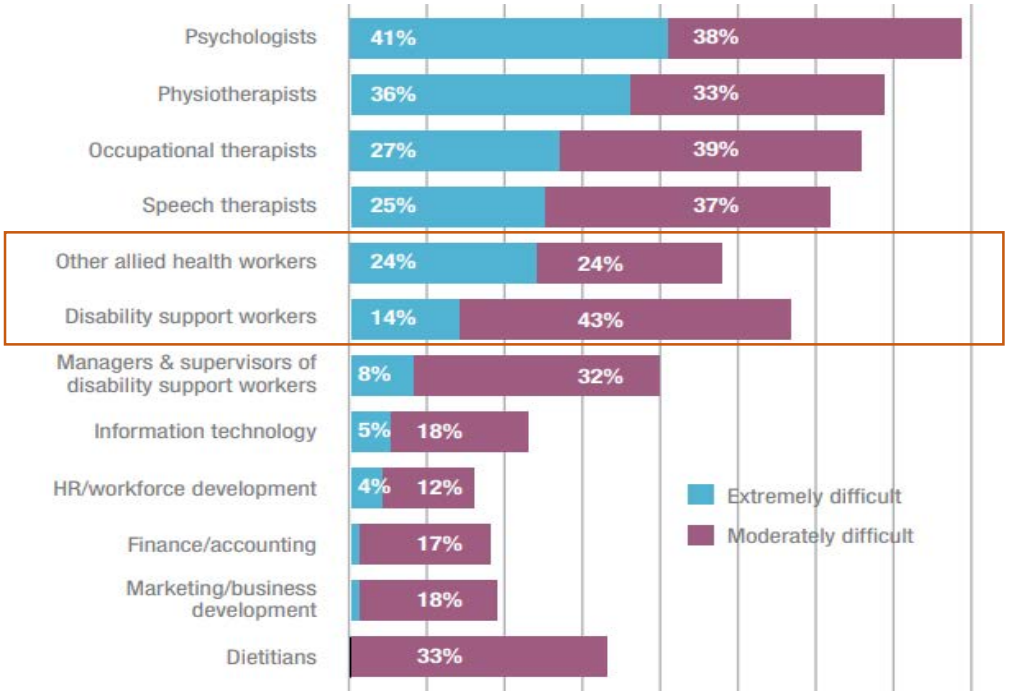
The said growth is projected to continue: per the economist Andrew Boak, *"We think there were probably about 50,000 additional jobs from the NDIS last year, and we might reasonably expect another 100,000 over the next few years."* It was further noted that *women* tend to dominate labor participation in the health care sector.

Despite this massive growth, Bill Shorten – leader of the Australian Labor Party – claimed that the said jobs growth was happening *"at the lower end of the labor market where wages are not increasing"* (The Australian, 2018). It was added that *a lot of the new jobs being created through the NDIS* are irregular

work, contract work, and casual work. Shorten also highlighted that the industry is a "feminized" one.

Related to the points discussed in the above findings is the Australia National Disability Services 2017 report which states that "*the data for the disability workforce paints a challenging picture*." The same report indicates that the average working hours remain low and working conditions are under pressure, making it tough to attract and retain staff – especially in some occupations and in rural and remote areas.

Figure 7: Difficulty Recruiting Competent Staff in the last 12 months



Source: Australia National Disability Services 2017 Report

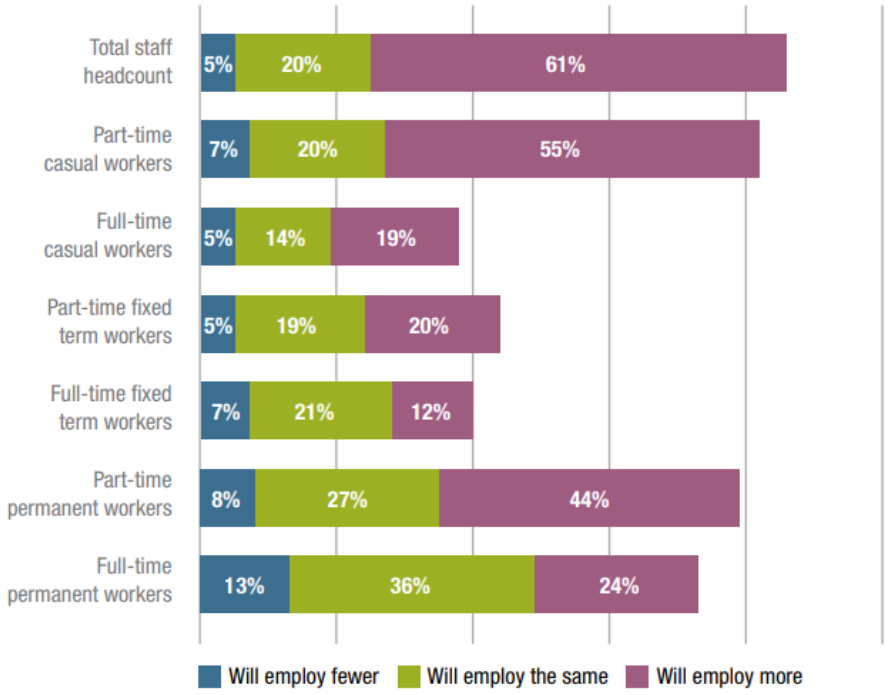
An alarming rate of around 60 per cent of disability service providers had moderate to extreme difficulty recruiting disability support workers.

Moreover, it was highlighted that underemployment in health care and social assistance is among the highest of any industry at nearly 11 per cent. Average hours worked for disability support workers is 21 hours per week and 24 hours per week for allied health professionals.

The average net workforce growth remains steady at three to four per cent each quarter with around three-fifths of disability service providers expecting their total headcount to be higher by the end of 2017-18. These figures show the disability labor market is not responding as quickly as we might expect. The NDIS transition is capping the ability of disability service providers

to offer competitive employment benefits and secure positions, while the changing structure of demand is also increasing constraints (State of the Disability Sector Report , 2017).

Figure 8: Employment intentions this financial year



Source: Australia National Disability Services 2017 Report

With the recruitment problems NDIS is facing, the survey shown above was implemented to display the employment intentions for 2018. The biggest recruitment will be made for part-time casual workers and part-time permanent workers. The least will be that of full-time fixed term workers.

In Japan, its government recently announced that it would create a new visa category to open the doors to new foreign workers starting in April 2019. Specifically, they passed legislation that extends Japan's Technical Intern Training Program to care work and revised Japanese immigration law by establishing the "care work," or kaigo, visa as a new category of legal residence. (Yūko , 2017) Japan expects acceptance of 345,000 blue-collar foreign workers during the first year of new visa policy. (Tanaka, 2018)

This represents a major policy shift because the law would create a new work visa status for lower-skilled workers and lower the bar on the level of Japanese required for workers applying to enter the country. Many industries in Japan are suffering from a severe labor shortage, the five particular industries chosen for this new program are the following:

- construction,

- agriculture,
- lodging/hospitality,
- nursing care;
- and shipbuilding.

In the nursing-care sector, which will be absorbing the largest share of foreign laborers, with 50,000 to 60,000 new hires expected, it is clear that extra labor is crucially needed. However, the government has not revealed whether home-visit nursing care will be included in the program. (Tanaka, 2018) However, in 2025, it is expected that the total caregivers needed will be around 380,000. (Yūko , 2017)

This represents a major policy shift because the law would create a new work visa status for lower-skilled workers and lower the bar on the level of Japanese required for workers applying to enter the country. Many industries in Japan are suffering from a severe labor shortage, but five in particular were chosen for this new program: construction, agriculture, lodging/hospitality, nursing care, and shipbuilding. (Murakami & Osaki, 2018)

In terms of employment intentions, more than 60% of companies in Japan report willingness to hire foreign nationals in skill-short areas, according to recruiting firm Hays.

In the US, Mercer's analysis shows that hospitals and other health care organizations should brace for a shortage of skilled health care workers, such as home health aides, nursing assistants, and clinical and lab technologists. The analysis stated that "Americans are getting older and less active, driving more of a need for home health and personal care aides across the country." Out of all skilled health workers, the supply and demand gap is expected to be the largest for home health aides. (ManagedCare, 2018)

Table 2: Health care occupations with projected supply gaps through 2025

Occupation	Growth	New job openings by 2025	Expected workforce gap by 2025
Home health aides	32%	423,200	–446,300
Nursing assistants	16%	407,396	–95,000
Medical and clinical lab technologists	13%	49,400	–58,700
Medical and lab technicians	18%	60,717	–40,000
Nurse practitioners	30%	51,445	–29,400
Physicians and surgeons, all other	16%	102,970	–11,000

Source: Mercer, "Demand for Health care Workers Will Outpace Supply by 2025: An Analysis of the U.S. Health care Labor Market," May 2018

More than half of the new jobs forecast by the US' Bureau of Labor Statistics (BLS) — about 1.6 million combined — will come from employment of personal care aides, home health aides and some types of nurses, driven by an American population that's trending older, sicker and more sedentary. It's in precisely these high-growth jobs where our analysis shows likely gaps in demand and supply of workers. Though nursing shortages grab the national headlines, our analysis showed a potentially greater labor risk in the lack of available talent to fill health care support occupations, in particular home health aides, with an expected workforce gap of about 446,300 workers by 2025. (Stevenson, 2018)

In terms of salary, the median annual full-time compensation for home health and personal care aides is only $23K, which is significantly below the median income among all jobs in the USA, which the BLS calculates to be $37.7K. (Formaspace, 2018)

V. Employment Challenges

According to Probono Australia, from the recent developments in the disability services sector, the challenges for the years ahead for Australia are identified below:

A. Highly casualized workforce

> "The pressure on service providers to be competitive, flexible and responsive has led to an increased demand for flexible working arrangements for the disability support workforce. The demand for flexibility has led to fragmented working hours and greater financial insecurity for casuals, many of whom have to undertake unpaid training which is not funded by the NDIS pricing arrangements. In reality, many workers juggle multiple jobs and are at greater risk of fatigue or failing to comply with minimum breaks between shifts."

B. Occupational health and safety challenges

> "Changing consumer demand for disability services in a residential setting has resulted to many services being delivered unsupervised at the client's home. While freeing for the worker, it also carries new and unexpected occupational health and safety risks. This means that you need to ensure that the environments you are instructing your workers to attend are safe, and that you are taking all reasonable steps to maintain that environment."

C. Risk of underpayments

> "The consumer driven market has led to demand for services on an irregular basis, at more unusual hours (i.e. not 9am to 5pm) and at different locations. For example, if an employee is starting to work outside of the standard nine to five hours, you will need to consider whether they are entitled to additional remuneration under the applicable modern award or enterprise agreement (i.e. additional break entitlements, penalty rates or TOIL).

D. Increased competition

> "There is no denying that by placing additional buying power in the hands of the consumer (or their family), competition amongst NDIS providers is likely to intensify as the scheme continues to roll out. Whilst the union report suggests that NDIS prices "incentivize cost cutting" for organizations to stay competitive, you should always make sure that you are paying your employees their minimum entitlements.

E. Sharing employees with multiple providers

> "With an increase in the number of providers in the NDIS space (and the increased reliance on casual employees), it is inevitable that some of your workers will be engaged by multiple organizations at the same time. There exists a potential for this arrangement to cause problems, such as breaching maximum engagement periods and risks of injury caused by fatigue."

According to Mercer, the following are the challenges faced by the US in the health care and social services sector:

A. Better wages for workers in the sector

> Health care organizations might have to compete against the retail industry, which offers better pay to lower-skilled workers. In the US, the pay for nursing assistants, home health aides, and personal aides "has stagnated at $10.11, a few cents lower than a decade ago, making recruitment more difficult," according to Mercer. (ManagedCare, 2018)

According to Nippon.com, even though Japan already has a system for training and recruiting foreign nurses and care workers under bilateral EPAs, the major reason challenge in securing adequate health care work personnel is:

A. Undesirable working conditions

> Many of the nurses and care workers who left Japan cite working conditions and long hours that made it impossible to balance work and family or proved injurious to their health. These are the same reasons Japanese nurses and care workers give for leaving the profession. In other words, Southeast Asian trainees are deterred by the same extreme conditions that drive Japanese women and men out of the profession. (Yūko , 2017)

B. Language Barrier and Certification exam

> The first exam under the Economic Partnership Agreements (EPAs) was taken by foreign care workers in 2009. The passing rate was 0%, but in the next two years the figure crept up slightly, to 1.2% in 2010 and 4.0% in 2011, and in 2012 it reached double digits at 11.3%. (Noriyuki, 2012) Recently, Japan has seen a sharp increase in the number of caregivers who have passed the national certification examination. According to the Japan's Welfare Ministry, a total of 213 foreign caregivers passed the fiscal 2017 exam, more than double the previous year's 104. (The Jiji Press, Ltd., 2018)

VI. Looking at the Philippines' TVET Health Care Workers

A. History

With the high demand for caregiving services globally, the TESDA Board promulgated Caregiving NC II in 2007. However, the proliferation of Technical-Vocational Education and Training (TVET) providers that offer Caregiving NC II prompted TESDA to issue a moratorium on the registration of Caregiving NC II training program through TESDA Circular No. 13, s. 2008 by the then TESDA Director General Augusto Syjuco, Jr. This included the suspension of the issuance of scholarship vouchers for Caregiving NC II. Moreover, the Moratorium prohibits incoming program registrations (programs already registered before the implementation of the moratorium can be re-registered). In the re-emergence of the demand of caregiving services, the moratorium was lifted in 2017.

In terms of salary, employed caregivers in the Philippines are being given a bare minimum monthly salary. The recent Caregiver Welfare Act

stipulates that the minimum monthly salary for caregivers should be as follows:

Table 3: Target Minimum Wage for Caregivers in the Philippines

Minimum Wage	Location
P7,500	National Capital Region (NCR)
P5,500	those chartered cities and first class municipalities
P4,000	other municipalities

Source: Senate of the Philippines

Currently, the bill is still pending in the Senate. If approved, it is an initiative envisioned to uphold the rights of caregivers to decent employment and income. However, some would argue that despite this, it is still incomparable to the salary of caregivers who are working abroad.

B. TVET Supply

As of June 2018 there are 336 TVET providers offering Caregiving NC II. NCR has the biggest number of TVET providers with 57; Regions III and XI have the lowest at 7.

Table 4: Number of Caregiving NC II Providers, June 2018

REGION	NO. OF TVET PROVIDERS
NCR	57
I	37
II	39
CAR	50
III	7
IV-A	14
IV-B	10
V	12
VI	15
VII	12
VIII	21
IX	15
X	11
XI	7
XII	39
CARAGA	50
Grand Total	336

Source: Certification Office

From 2013 to 2015, the number of persons assessed and certified has decreased from 16,129 to 12,633 and 15,139 to 12,124, respectively. In 2016, however, the number of persons assessed and certified has increased to 18,657 and 18,024.

Table 5: Number of Enrolled, Graduated, Assessed, and Certified, Caregiving NC II, 2013-2017

YEAR	ENROLLED	GRADUATED	ASSESSED	CERTIFIED
2013	6,701	5,981	16,139	15,139
2014	10,943	9,178	17,518	16,649
2015	6,259	6,018	12,633	12,124
2016	9,328	8,054	18,657	18,024
2017	10,847	7,874	20,311	19,681

Source: 2016 - 2017 MIS 03-02, TESDA

C. Requirements for Employment

1. Australia

The recent updates on the training packages for allied health assistants in Australia is an attempt to promote consistency and standardization of vocational training delivered to health assistants.

Formal qualifications for health care assistants are available through the vocational education and training sector and are based on the achievement of competencies, delivered via registered training organizations such as Technical and Further Education (TAFE) institutions, which offer a Certificate III and Certificate IV in Allied Heath Assistance (Munn Z. , et al., 2010).

Last 2016, a training package review conducted by the Community Services and Health Industry Skills Council (CS&HISC) saw the entry level qualifications for aged care change (Munn Z. , et al., 2010). The reason for this is to ensure that tasks are carried out by staff with the right level of skills, experience and competency.

Recent health care redesign in Australia has been directed at providing more equitable, accessible, efficient and effective patient care. This was driven by the increase in health assistants

across *medical-related professions*. The increase also led to the national introduction and endorsement of training programs for the allied health assistants.

The updated qualifications allowed specialization while addressing commonalities that exist within the sector. It also addressed issues on the varying costs and time spent in training.

At the Certificate III level, a new qualification – Certificate III in Individual Support – replaced the Certificate III in Aged Care, Certificate III in Home and Community Care and Certificate III in Disability. Under this qualification, a student completes a common, general core of subjects, and can then choose to specialize in up to two areas: ageing, home and community or disability (Keast, 2016).

In Australia, formal training is neither mandatory nor often required of allied health assistants and they may have either minimal to no experience or plenty of experience but with no formal qualifications, receiving only "on the job" training from the supervising health professional (Stute, Hurwood, Hulcombe, & Kuipers, 2014).

However, to be eligible for sponsorship, ***health assistance workers need to obtain Australian recognition of their overseas qualification***. They also have to register with the appropriate registration authority in Australia. Applicants who require qualification recognition and registration should contact the Australian Health Practitioner Regulation Agency (AHPRA) (Government of South Australia, 2018). The agency also has a database in their website that employers use to verify whether applicants are registered. The website also serves as a platform to report complaints on a certain registered practitioner.

In Queensland, the Allied Health Professions' Office of Queensland has developed a series of contextualized learning modules designed to assist the rapid on-boarding of new allied health assistants in a number of clinical practice areas. These resources may be used by allied health assistants seeking recognition of prior learning toward the Certificate IV in Allied Health Assistance from a Registered Training Organization.

Another option would be to study under an Australian-accredited training institution. The Australian government offers one qualification in health assistance through its CHARLTON

BROWN® Partner Institutions in the Philippines- Certificate III in Aged Care.

According to the Australian Embassy Website, "the Certificate III in Aged Care offered in the Philippines is aimed at developing skills in a range of areas including: supporting an older person in the activities of *daily living, provision of support for individuals with dementia, working effectively with culturally diverse clients and colleagues and providing social, physical and psychological care.* This course has an ideal balance of theory and practical learning to ensure the students' confidence when entering the workforce globally. The employment outcomes include positions such as Assistant in Nursing, Personal Care Assistant, Community Support Worker and Home Care Assistant. The Certificate III in Aged Care (Theoretical Component) is studied in the Philippines while the Practical Component (On the Job Training) will be completed in Australia. The students will receive the full Australian Qualification – Certificate III in Aged Care upon completing both the theoretical and practical components of the course. The students who completed the theoretical component of Certificate III in Aged Care from CHARLTON BROWN® Partner Institutions in the Philippines will come to Australia to further their studies in the Community Service Sector under Subclass 572 Visa" (Australian Qualifications and Courses in the Philippines, 2018).

2. Japan

As previously mentioned, Japan already has a system for training and recruiting foreign nurses and care workers under bilateral EPAs with three countries in the region, Indonesia, the Philippines, and Vietnam.

Under the EPA programs, qualified applicants receive Japanese language training, followed by professional training at a Japanese medical or care facility. The Care workers are also required to have a certain number of years as experience, depending on whether they will be seeking jobs in a health care facility or as personal care givers before qualifying for the board exam.

A certain level of Japanese proficiency equivalent to at least N3 (under the five-tiered Japanese-Language Proficiency Test) is considered essential to pass the national board examination for care workers. This

If they pass the national board examination, they are then eligible to work in Japan indefinitely, renewing their residence status every three years. Candidates invest a great deal of time and effort to complete their training and earn their license, as do the facilities that take charge of their training. However, 16%–38% of those who passed the national board examination have returned home instead of staying on in Japan. (Yūko , 2017)

Also, in conjunction with enforcement of the new Technical Intern Training Act, 'Care Worker' occupations were added to the occupations subject to transfer under the Technical Intern Training Program.

In line with this, the Department of Labor and Employment (DOLE) has set the guidelines for accepting Filipino care workers for the Technical Intern Training program in Japan. The Department Order No. 188-B issued by DOLE indicates the qualifications of eligible applicants.

According to the Philippine Information Agency, for care worker job category, those who will be accepted as care worker intern can be engaged in duties such as providing services under the Child Welfare law; law on Comprehensive Support for the Daily Lives and Social Lives of Persons with Disabilities; Elderly and Long-Term Care Insurance law; Public Assistance law; and other services, such as for community welfare center, work accident special nursing home business, hospitals, and clinics.

The trainee must be at least 18 years old, must have at least one (1) year work experience in the 'Care Worker' industry or in similar professions, whether abroad or locally, and must be a first-time participant of the program.

Should an applicant lack related work experience, he or she must have a Caregiving NC II Certification from TESDA – Accredited training center or a 4-year Bachelor's Degree in healthcare related course provided that they submit authenticated copies of diploma and transcript of records.

The key requirements for the internship training also include passing the N4 Level of the Japanese Language Proficiency Test (JLPT) or its practical test equivalence; a score of 350 or more in the E-F Level test or 400 or more in the A-D test of the J Test (Test of Practical Japanese) implemented by the Japan Language Examination Association; and passing at least level 4 of the Japanese Language NAT-TEST.

Furthermore, an intern can be qualified for the 2nd year of the training if he/she completes either passing N3 Level of the JLPT; scoring 400 or more in the A-D test of the J. Test, or passing at least level 3 of the Japanese Language NAT-TEST within the 1st year of training in Japan.

Trainee care workers who failed to pass the N3 level within one year of the training will be disqualified to complete the program and will be repatriated back to the Philippines in accordance with Japanese regulations.

On the other hand, the Philippine Overseas Employment Administration shall carry out the accreditation of supervising/implementing organizations to implement the TIT for the care worker job category.

3. United States of America

The training and certification requirements for these jobs vary state by state. However, in nearly all settings, the major drawback in hiring local citizens is the low salary: the median annual full-time compensation for home health and personal care aides is only $23K, which is significantly below the median income among all jobs in the USA, which the BLS calculates to be $37.7K. (Formaspace, 2018)

This doesn't seem like a problem for Filipinos who are interested in working in the US because the salary is still much bigger than what is offered in the Philippines.

As a general rule, caregivers who help with the tasks of day-to-day living, such as cooking, companionship, and personal care, may not need to be licensed; licensing or certification is required for home health aides (HHAs), certified nursing assistants (CNAs), and others providing medical care.

The minimum educational requirement for caregiver - Certified Nursing Assistants (CNAs) is a high school diploma or its equivalent. However, specific training requirements, such as having CPR certification, may vary by state or employer. The U.S. Bureau of Labor Statistics (BLS) maintains that CNAs who wish to work in a healthcare facility are federally required to complete no less than 75 hours of state-approved nursing assistant training and take competency exams. Though caregiver CNAs may choose to work

in the private sector, helping clients who wish to continue living in their own homes, it may prove helpful for them to have additional training and certification. (Caregiver CNA: Education Requirements and Career Information, 2018)

Some additional requirements include that applicants should be in good physical health. They may be asked to provide proof that they are drug-free and submit to a criminal background check. In addition, having reliable transportation and a valid driver's license may prove helpful.

VII. Way Forward

The developing countries' health system has become increasingly reliant on foreign-born health workers. This raises questions of medical education sustainability which is almost always addressed through recruitment from other countries such as the Philippines.

The Philippines on the other hand, is confronted with problems of unemployment. This could become a win-win situation for the countries involved if they make the most out of the existing circumstances.

Facilitation of foreign employment necessitates the governments to coordinate both locally and internationally. As of writing, engagements with concerned Philippine government agencies, along with these countries Embassies, are underway.

Specifically, the Department of Foreign Affairs has already made its first step through communicating to the concerned government agencies including TESDA, the employment opportunities resulted from the insitutionalization of the NDIS Australia.

On the other hand, there is a continuous supply of home aides and personal aides coming from the country to the United States. For Japan, there has been a previous partnership with TESDA in order for Caregiving NC II graduates to be able to land a job in their country. However, the partnership was faced with a major problem when the Filipino Caregivers were required to pass a qualifying exam in Japanese which resulted to most of them failing and therefore, not being employed in Japan.

This is a crucial starting point for undertakings of this nature as this will provide the actual *skills needs* of the three countries and also cater to local employment demand. Based on the gathered information, it can be concluded that among the existing TVET programs, Caregiving NC II is the most related qualification that can be considered in the identified job shortages.

However, it is imperative to also reflect on the specific skills and certification requirements set by these governments, as indicated in related literatures.

To address foreseen issues that may hinder Filipino workers to avail this employment opportunities, the following actions are recommended:

1. Bilateral discussions should be initiated between the Philippines the employing country as this will help in better employment facilitation of caregivers from the Philippines. The gaps such as the need for qualification recognition in Australia and United States should be addressed during the planning stage of possible agreement between countries. This may lead to the crafting of bilateral agreement that will provide reference on the possible employment of Filipino workers. As for Japan, the previous problems such as the language requirement for passing the Japanese board exam should be addressed.

2. With the considerable investment these countries have for the sustenance and improvement of their health care and assistance industry, it is only expected that they will require the future health care assistance workers to comply with their respective qualification requirements. With this, TESDA should guarantee its training regulations to be at par with their industry requirements. Whether it is a new training regulation to be developed or an existing one to be revamped, all will be contingent on the agreements to be reached by the countries. Likewise, TESDA may look into one of the strategies identified in the NTESDP 2018-2022, the adaption and adoption of international standards for TVET to quickly align its training programs to the needs of the industry.

3. Another critical requirement is the certification of Filipino workers. Recognition on the certification that the Philippine government will issue should also be established or worked with the receiving country. This is to avoid having an additional ladder for the Filipino workers to go through before they are able to work abroad. Existing issues on certification recognition experienced with current bilateral agreements can be the basis in the formulation of the policies.

4. For TESDA, depending on the actual demands, the Training for Work Scholarship Program (TWSP) could be adjusted. Should there be a lack of workforce supply, scholarship allocations could be refocused to Caregiving NC II. This will promote the training which can therefore attract more enrollees. The increase in the number of graduates of the Caregiving program will invigorate the industry which will not only cater to the needs of the Australia's, Japan's and US' health care industry but will also increase the employment opportunities of TVET graduates.

5. Furthermore, it is also important that the issues discussed in this report (highly casualized workforce, underemployment, occupational health and safety challenges, etc.) also be discussed during meetings to ensure that decent and just jobs will be given to overseas Filipino workers. The Department of Labor and Employment, Philippine Oversease Employment Authority and Overseas Worker Welfare Administrations should be mindful of these arrangements and must take the lead in developing mechanism/s that will ensure that Filipino workers are protected.

With right policy direction and careful management, Australia's, Japan's and US' health care system's current demand and the future demand for carers of other medically-advanced countries could contribute in addressing the Philippines' unemployment problem.

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