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Asia–Pacific Sectoral Labour Market Profile: Health and social work*

Key points

- In 2021, an estimated 47 million people in the Asia-Pacific were employed in the health and social work sector. However, significant labour shortages exist, highlighting the need for greater investment.
- Workers in the health and social work sector were at the forefront of the COVID-19 pandemic and continued to work throughout the pandemic as essential workers. While temporarily acknowledged as heroes over the course of the pandemic, many workers in the sector continue to face decent work challenges, including gender pay gaps, long hours and above average levels of work-related mental stress and anxiety.
- The sector's workforce is largely wage and salaried employment, however, there are signs that the quality of work is impacted by decent work deficits including the existence of informal employment, long working hours and temporary contracts.
- The pandemic has highlighted the need for bolstering the resilience of the health and social work sector. While outcomes in terms of access to health and social care services is important, there is also a need to focus on the means of achieving these outcomes, through investment in education, training and resources.

▶ Background

The health and social services industry[2] has been integral to the Asia–Pacific region's growing economic prosperity. Beyond its contribution to GDP, the sector makes an unmeasurable contribution in terms of its effect on the health, well-being, human capital and productivity of populations. Health services is critical for achieving various Sustainable Development Goals (SDGs), particularly SDG 3 on ensuring healthy lives and promoting well-being for all at all ages, SDG 4 on quality education, SDG 5 on gender equality and SDG 8 on decent work and inclusive economic growth. The sector is also an important and increasing source of jobs, especially for women.

The health and social work sector was at the forefront of the COVID-19 pandemic. Designated as "essential

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[2] The health and social work sector corresponds to International Standard Industrial Classification of All Economic Activities (ISIC) Revision 4 major group Q and included divisions 86 (Human health activities), 87 (Residential care activities) and 88 (Social work activities without accommodation).

workers", many in the sector saw their working hours and their work stress increase significantly. Doctors, nurses, long-term care givers and support staff put their own lives at risk and compromised the safety of their families to provide care through intensely stressful circumstances.

This brief provides an overview of the characteristics of the health and social work sector, with a focus on employment characteristics and sectoral governance. The first section looks at economic characteristics of the sector, followed by employment trends. The following section provides an overview of characteristics of those employed in the sector before looking at sectoral governance factors, including policy responses relevant to the sector during the pandemic. the brief concludes by considering the industry outlook for the promotion of decent work.

► Sectoral economic and employment trends

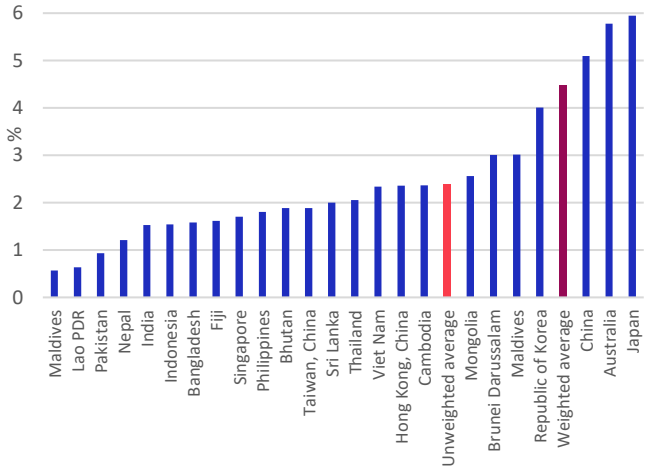
The health and social work sector has an unmeasurable contribution to the economy beyond GDP

The health and social work sector accounted for between 0.5 and 6 per cent of GDP in different countries of Asia and the Pacific in 2020 (figure 1). On average, of the 24 countries with available data, the health and social work sector accounted for around 2.4 per cent of GDP (when weighted by population, this rises to 4.5 per cent). Beyond GDP, the health and social work sector makes a significant, though unmeasurable, contribution to the economy in terms of its contribution to the health, well-being, human capital and productivity of the population and workforce of each country.

Health and social work services are typically provided through a mix of public and private enterprises, depending on the national context. According to the World Bank, in the region of East Asia and the Pacific, domestic government expenditure accounted for around 66.2 per cent of public healthcare expenditure, and 31.2 per cent in South Asia, in 2019.[3]

The share of total expenditure on healthcare attributed to domestic government expenditure increases with the level of development. For instance, in high-income countries such as Brunei Darussalam and Japan, domestic government expenditure accounted for around 94 per cent and 84 per cent, respectively, of total expenditure on healthcare. This is in contrast to Afghanistan, Myanmar and Bangladesh, at 8 per cent, 16 per cent, and 19 per cent, respectively. The source of funding has implications for the scope and quality of healthcare services available to the population, but also for the demand for workers in these sectors and the conditions of work, including pay.

► **Figure 1. Health and social work sector, share of GDP, 2020 (per cent)**



Note: The average of 24 countries in Asia-is shown with and without population weighting
Source: ILO estimates based on Asian Development Bank, Multi-regional Input-Output (MRIO) Database.

During the pandemic, the healthcare sector, saw resources redirected towards the COVID-19 response. Globally, this contributed to a reduction in healthcare services for non-COVID-19 related issues.[4] Both the sources of funding and the resources available point to

[3] Data from WHO Health Expenditure database, reproduced on The World Bank DataBank at https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS. The World Bank grouping of East Asia and Pacific includes South-East Asian countries.

[4] R. Moynihan et al., "Impact of COVID-19 Pandemic on Utilisation of Healthcare Services: A Systematic Review", *BMJ Open* 11, No. 3 (2021).

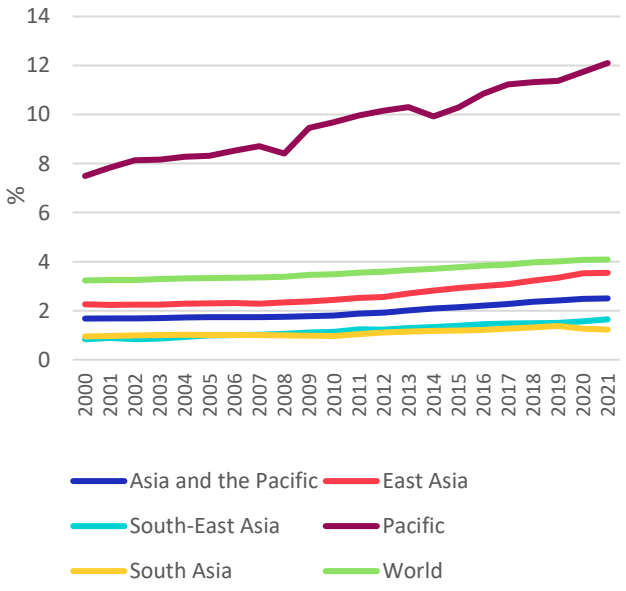
the need for increased and sustained investment in the sector.

With population ageing and an increasing demand for health care services driven in part by a sizeable expansion in the region's middle class, as health care services expand, there are often challenges in recruitment of the needed workforce. Labour shortages in the sector pose a challenge for many countries in the region. In South-East Asia, it is estimated that the labour shortfall in health workers was equivalent to 6.9 million in 2013, and based on the current trajectory, will still be 4.7 million short in 2030.[5]

Health and social work employ nearly 47 million people in Asia and the Pacific

In Asia and the Pacific, a total of 47 million people were employed in the health and social work sector in 2021. This is equivalent to 2.5 per cent of the region's total employment, an increase from 1.9 per cent of total employment a decade earlier (figure 2).

► **Figure 2. Share of health and social work in total employment, 2000–21 (per cent)**

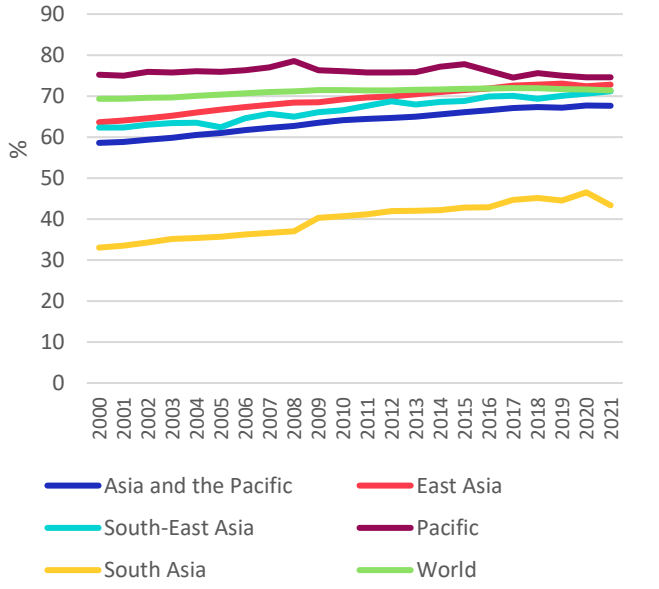


Source: ILO modelled sectoral estimates, November 2022.

By subregion, the sector accounted for between 1.2 per cent of total employment in South Asia and 12.1 per cent in the Pacific in 2021. All subregions show increases over time in both total employment in the sector and the sector's share in total employment.

The health and social work sector is heavily feminized, meaning the share of female employment in the sector is high. A total of 67.6 per cent of employment in health and social work in the Asia–Pacific region was accounted for by women in 2021 (figure 3). This is similar to global trends, where the female share of employment was 71.4 per cent. The only Asia-Pacific subregion that is off trend is South Asia, where women accounted for only 43.3 per cent of employment in health and social work.

► **Figure 3. Share of women in health and social work employment, 2000–21 (per cent)**



Source: ILO modelled sectoral estimates, November 2022.

Care activities are also heavily feminized, with women accounting for nearly 9 out of every 10 personal care workers globally.[6] Those working in care activities range from qualified nurses to persons providing care with no formal training. These workers provide a range of care services, including health, personal care and assistance with mobility and activities. At the same time, women also

[5] World Health Organization, Global Strategy on Human Resources for Health: Workforce 2030, 2016.

[6] Care activities refers to the grouping "personal care workers", classified according to the International Standard Classification of Occupation, Revision 2008, category 53. The occupation may or may not fall within the health and social work sector. The global estimate is based on data for 121 countries and does not include China or India. See ILO, "These occupations are dominated by women", ILO Blog (2020).

take the burden of household care activities, on an informal and unpaid basis.[7]

Around 9 per cent of employment in the health and social work sector was accounted for by youth (aged 15–24) in the Asia–Pacific region in 2021. Youth were more likely to be employed in the sector in South-East Asia, with a 12.5 per cent share in the sector's total employment, followed by the Pacific (11.2 per cent) and South Asia (11 per cent). In East Asia, youth accounted for 7.8 per cent of total employment in the sector.

COVID-19 crisis brought job growth to the sector, but not for all subregions

The sector's increasing share of employment has been incremental over time. During the COVID-19 pandemic, the sector was one of the few in the region that did not shed workers.[8] A further 1.6 million jobs (3.6 per cent increase) were gained in health and social work in the Asia-Pacific region (2019–21). While noteworthy, the job growth during the COVID-19 period was significantly less than the average annual increase of 4.1 per cent per annum between 2010 and 2019. This suggests that despite job creation in the health and social work sector, there was also considerable job losses.

The job losses in the sector during the COVID-19 pandemic were concentrated in the South Asia subregion. Employment in the sector shrank by nearly 900,000 in South Asia, equivalent to a decrease of 9.9 per cent of the sector's employment over the period 2019–21.

In contrast, there was a surge in employment in the health and social work sector during the pandemic period in South-East Asia and the Pacific . In East Asia, while the annual job growth in the COVID-19 period was high (3.2 per cent), it was slightly below that of the pre-COVID period (3.7 per cent).

Globally, there is evidence of occupational gender segregation within the health sector, with women being more likely to be nurses, midwives and community health workers and cleaning and catering staff, and men more likely to be physicians, dentists and pharmacists.[9] With occupational differences came different levels of risk faced by men and women within the health sector during the COVID-19 pandemic.

Workers in the health and social work sector, as essential workers, were mostly required to continue working during the pandemic. The occupational health and safety of workers in the sector was tenuous during the pandemic, depending on the access and availability of personal protective equipment (PPE) and access to sick leave and sick pay.[10] Workers that did not have access to paid sick leave, were more likely to stay on the job even when exposed to the virus and, in so doing, to contribute to the further spread of COVID-19 to others in the workplace. At the same time, many healthcare workers faced long working hours and extremely stressful working conditions during the pandemic.

► Employment characteristics in health and social work

Despite high shares in wage employment, decent work deficits exist also in health and social work

Most workers in the health and social work sector are engaged as wage and salaried workers. The share at the regional level in 2021 was above 93 per cent (figure 4). This is likely a reflection of the institutional attachment and settings in which much of the work takes place, i.e. in hospitals and healthcare facilities, nursing and care facilities, thereby reducing the scope for activities suitable for own-account workers. For all subregions in Asia and the Pacific, the wage and salaried employment share was above 85 per cent in 2021. The share of workers in wage employment increased in all subregions over the period 2000–21 except the Pacific.

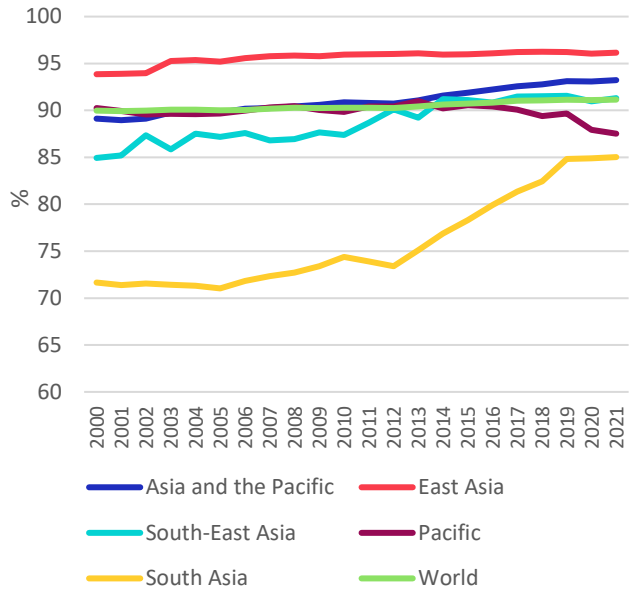
[7] ILO, A quantum leap for gender equality: For a better future of work for all, 2019.

[8] See ILO, Asia–Pacific Employment and Social Outlook 2022: Rethinking sectoral strategies for a human-centred future of work, 2022, section 3.5.

[9] UN, Policy Brief: The Impact of COVID-19 on Women, 2020.

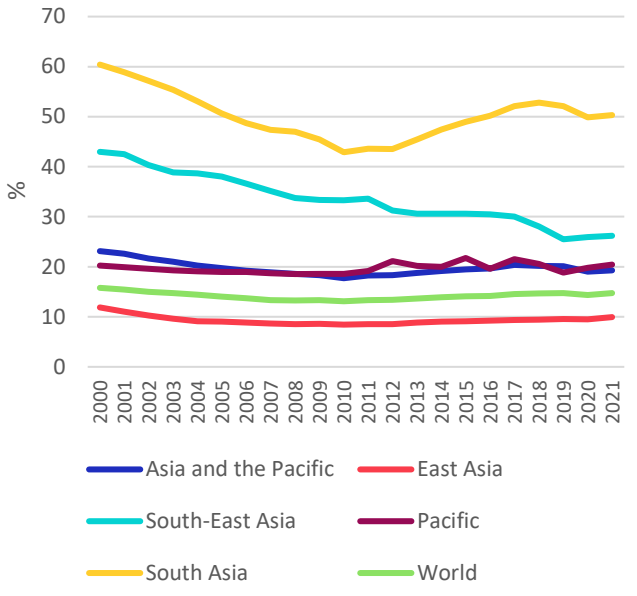
[10] C. Y. Park et al., Global Shortage of Personal Protective Equipment Amid COVID-19: Supply Chains, Bottlenecks, and Policy Implications (ADB, 2020).

Figure 4. Share of wage employees in total employment in health and social work, 2000–21 (per cent)



Source: ILO modelled sectoral estimates, November 2022.

Figure 5. Informal employment share of employment in health and social work, 2000–21 (per cent)



Source: ILO modelled sectoral estimates, November 2022.

Wage and salaried employment is typically associated with higher degrees of job stability, regular incomes and better conditions of work. However, in the Asia–Pacific region, wage and salaried employment is no guarantee of quality jobs. In terms of informality, for instance, about half of total employment in the sector in South Asia was informal, despite 85 per cent of the subregion's employment being in wage and salaried employment. Similarly, but to a lesser extent, 26 per cent of total employment in the sector in South-East Asia was informal, despite 91 per cent of the subregion's sectoral employment being wage and salaried employment. What this means is that despite being paid by an employer on an hourly or monthly basis, many health care workers remain without regular contracts and without access to entitlements like paid annual and sick leave.

In terms of wage levels, only 10 per cent of paid employees in the health and social work sector in the Asia–Pacific region fell in the category of low-pay employment (based on hourly pay).[11] This is similar to the global average of 10.5 per cent. However, by subregion, the share of low-pay workers in the health care sector was as high as 22 per cent in South Asia and 18 per cent in the Pacific.

The relatively low share of low pay employment in the health and social work sector in the region and globally is consistent with the relatively high share of high-skilled occupations in the sector.[12] A total of 67 per cent of total employment in the health and social work in the Asia–Pacific region were high-skilled occupations. It highlights the potentially wide disparity in earnings owing to the range of occupations that sit within the sector. With women more likely to be in low and medium skilled occupations, there remains a significant disparity between earnings of women and men in the health and social work sector. Research on the gender pay gap in the health and

[11] The share of low paid employees is defined as the share of wage employees whose wages are below two thirds of the median hourly wage in a given country and year. The hourly wage is calculated from data on wages and actual hours worked available in national labour force surveys. See Annex 3 of ILO, Asia–Pacific Employment and Social Outlook 2022, op cit. for information on the estimation methodology used to produce regional aggregates.

[12] The share of employment in high-skill occupations is defined as the share of workers classified in the following occupations: managers, professionals, or technicians and associate professionals, following the International Standard Classification of Occupations (ISCO-08).

care sector during the COVID-19 pandemic shows that across the world men were overrepresented in higher deciles of pay in the health and social work sector, resulting in significant gender pay gaps.[13] In Asia and the Pacific, where data is available, significant gender pay gaps in the sector were observed in Australia, Bangladesh, Nepal, Sri Lanka and Viet Nam.

The increased demand for health services during the COVID-19 pandemic led in some cases to excessive working hours in the sector. Some countries hence saw a substantial increase in working hours in the subsector of "human health activities" (ISIC Revision 4 division 86). For example, Pakistan saw an increase in the average weekly hours worked per employed person in the subsector from 47.7 in 2019 to 49.7 in 2021. Similarly, the average weekly hours worked increased in Viet Nam from 44.1 in 2019 to 44.8 in 2020 and 44.9 in 2021.[14]

► Sectoral governance and promotion of decent work

Keep the momentum on increased public investment in the health and social work sector

Pre-existing labour shortages in some countries were amplified by the pandemic. To address manpower shortages during COVID-19 peaks, some countries mobilized healthcare volunteer corps and assigned armed forces personnel to support hospitals, including temporarily constructed field hospitals, assist with contract tracing and spreading health and safety information in rural areas.[15] The Asian Development Bank (ADB) helped support a number of healthcare systems in the region to handle the surge in demand, as well as help address bottlenecks in supply chains.[16]

The ASEAN Comprehensive Framework on Care Economy was initiated to strengthen the resilience of ASEAN Member States to different types of crises, including the COVID-19 pandemic, changing demographics and climate change.[17] The Framework seeks to "chart out the strategic priorities, map out the relevant sectoral initiatives, establish implementation mechanisms and timeline for the realization of an ASEAN Care Economy that should be jointly implemented by ASEAN Member States".

Implementation of the Framework requires a whole-of-ASEAN approach. it should be noted that the Framework was initiated prior to the onset of the COVID-19 pandemic but was since reframed to incorporate COVID-19 specific issues.

The Framework is mostly focused on the outcomes of an improved and more resilient care economy, and does not explicitly outline investments, interventions and support mechanisms to facilitate this, but implicitly the processes will entail investment in workers in the health and social work sector. There are some explicit mentions of how these workers will be better equipped and will receive support, for instance, in terms of disaster risk management, the framework looks to train different types of care providers, including healthcare workers, social work professionals, counsellors, psychologists and community-based care providers, with the requisite skills to be able to respond accordingly to disasters.

The ASEAN region has in place a Mutual Recognition Agreement (MRA) that promotes the mobility of medical practitioners with the ASEAN region.[18] The MRA seeks to (i) facilitate mobility of medical practitioners within ASEAN; (ii) exchange information and enhance cooperation in respect of mutual recognition of medical practitioners; (iii)

[13] WHO and ILO, The Gender Pay Gap in the Health and Care Sector: A Global Analysis in the Time of COVID-19, 2022.

[14] Data are from ILOSTAT.

[15] Indonesia, Singapore and Thailand are examples. See: "Thailand's 1 million village health volunteers - "unsung heroes" - are helping guard communities nationwide from COVID-19", WHO blog, 28 August 2020; "Nurses and volunteers wanted amid healthcare manpower shortage as Covid-19 cases surge", The Straits Times, 20 February 2022; Y. Mahendradhata et al. The Capacity of the Indonesian Healthcare System to Respond to COVID-19, *Frontiers in Public Health*, 7 July 2021.

[16] C. Y. Park et al., Global Shortage of Personal Protective Equipment Amid COVID-19: Supply Chains, Bottlenecks, and Policy Implications, op cit.

[17] ASEAN, ASEAN Comprehensive Framework on Care Economy, 2021.

[18] ASEAN, ASEAN Mutual Recognition Agreement on Medical Practitioners, 2009.

promote adoption of best practices on standards and qualifications; and (iv) provide opportunities for capacity building and training of medical practitioners.

This MRA was established in 2009 and the impact of the MRA on the mobility of medical practitioners has been assessed in a number of different studies. A literature review of different studies found that implementation of the MRA was complicated which impacted the uptake by the region's medical practitioners, and also other barriers emerged, including signs of preference to migrate to non-ASEAN countries, as well as some barriers to entry for foreign workers in national healthcare systems. In Cambodia, for instance, there was evidence that despite having a surplus of trained nurses, the MRA had not contributed to an exodus of these nurses.[19]

Enforcement of labour standards and collaborative actions to reduce decent work deficits

Decent work for health workers is essential to provide quality health care. Safeguarding decent working conditions in the health and social work sector requires the adoption and enforcement of relevant international labour standards, including the Nursing Personnel Convention, 1977 (No. 149), the Nursing Personnel Recommendation, 1977 (No 157), and the Labour Relations (Public Service) Convention, 1978 (No. 151).

Decent working time arrangements, access to social protection and the right to collective bargaining are among the core elements to promoting a healthy and productive workforce that can effectively deliver the essential services of the health and social work sector. Various guidelines exist with the aim to influence action at the national level to address gaps in sectoral governance, including the WHO Global Code of Practice on the International Recruitment of Health Personnel (2021) and the ILO and WHO Occupational Safety and Health in Public Health Emergencies manual (2018).[20] Yet the effective application of such guidelines can still be lacking. Policy coherence and coordination at all levels is essential to ensure effective and quality health systems and services, taking into account relevant international labour standards and guidance and tools developed by the WHO and other international and regional organizations.

Facilitating social dialogue at the sectoral level is also critical to addressing the challenges regarding decent work in health and social work services. Health and social workers are not excluded from the right to organize or collective bargaining, where such rights exist, but for health workers, there are some legal restrictions or conditions on the rights to strike, on the basis of the essential nature of their services.[21] For care workers in general, there are fewer options available with regards to unionization and collective action, not least owing to the high degree of voluntary care work.

According to limited available data, around 36 per cent of employees in human health activities in India were part of unions in 2012, compared to 14 per cent of those in residential care activities, and 48 per cent of those in the social work activities without accommodation subsector.[22] In Cambodia, the share of employees in human health activities who were members of unions was less than 10 per cent.

► Way forward and prospects for decent work

The health and social work sector is an important growing source of employment in the Asia–Pacific region. In 2021, the sector absorbed 2.5 per cent of all workers in the Asia and the Pacific region. Unlike most sectors, employment in health and social work continued to grow during the COVID-19 pandemic, reflecting the integral work within the sector in caring for infected persons, facilitating vaccination programmes and outreach to protect lives through lockdown operations.

[19] K. Law, V. Te and P.S. Hill, Cambodia's health professionals and the ASEAN Mutual Recognition Arrangements: registration, education and mobility, *Human Resources for Health* No. 17 (2019).

[20] WHO, WHO Global Code of Practice on the International Recruitment of Health Personnel (2021); ILO and WHO, Occupational safety and health in public health emergencies: A manual for protecting health workers and responders, 2018.

[21] ILO, Improving Employment and working conditions in health services, 2017.

[22] ILO estimates based on microdata set of national Labour Force Surveys.

As some jobs in the sector are dependent on medical tourism, also the health and social work sector is benefitting from border reopenings and easing of restrictions. The sector is expected to benefit greatly from the resurgence of international tourism as well as the related boost in demand for health services. Yet, recapturing the region's pre-pandemic growth trajectory will not be automatic and will require supportive government engagement.

The region's health and social work sector is characterized by wage and salaried employment. This status in employment typically carries more job security, regular incomes and benefits, including sick and annual leave, as well as providing more opportunities for training and skills development. However, what is also evident in the region is that despite the high share of the health and social work sector in wage and salaried employment, several areas of decent work deficits still exist. These include long working hours and temporary contracts, as well as some degree of informal employment.

At the same time, the COVID-19 pandemic highlighted the vulnerability of the workers in the health and social work sector, despite their essential worker status. They carried a disproportionate level of exposure to COVID-19 via the nature of their occupations and also were faced with shortages with regards to PPE and other health supplies. The impact on these workers is all the more important to assess given the highly feminized nature of the industry, where around 70 per cent of those employed in health and social work are women.

While health and social care can be considered a form of social protection, there is a need to focus not only on the outcomes of scaling up and investing in health and social care, namely enhancing coverage and breadth of services available, but also the means of scaling up. This entails enhancing the capacity of healthcare workers, investing in skills development and education and ensuring needs of the workers are met, particularly through social dialogue.

Contact details

ILO Regional Office for Asia and the Pacific
United Nations Building
Bangkok 10200
Thailand

T: + 66 2 288 1234
E: BANGKOK@ilo.org
W: www.ilo.org/asiapacific