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Securing The Future: A Model of Social Insurance for Long-Term Care in Malaysia

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Preamble

This paper is the second part of a two-part study examining the imperative for long-term social protection systems. The first paper, *Living Longer and in Need of Care: Should Long-Term Care Benefits Be Introduced in Malaysia's Social Protection System?*[1] presented a statistical and analytical foundation, highlighting the demographic, economic, and social arguments that underscore the urgent need for intentional and sustained long-term care strategies. Building on that groundwork, this second paper shifts focus toward actionable policy design - offering recommendations for structuring long-term care benefits within an integrated social protection framework.

To fully appreciate the rationale and relevance of the proposals discussed here, readers are strongly encouraged to read both papers in tandem. Together, they form a cohesive narrative that moves from evidence to implementation.

Introduction

As Malaysia's population ages, the demand for long-term care (LTC) services is rising at an unprecedented rate, posing significant financial and social challenges for individuals, families, and the country's public health system. Malaysia is one of the countries that has yet to invest in formal, public LTC systems. Where there is no formal LTC system, the pressures and costs of accessing needed care are shifted to the health system, individuals and their families.

Government intervention in LTC is needed for several reasons beyond the shortcomings of the private insurance market. While the design, implementation, and effectiveness of such systems vary widely across countries, and their respective capacities to remain sustainable in the face of escalating costs and greater number of care-needing individuals, there are sufficiently broad lessons for Malaysia to consider when designing its own national LTC system.

This brief paper sets out recommendations on various features of an inclusive nation-wide **LTC benefit program** that can provide financial protection, ensure access to quality care, and mitigate the economic burden arising from LTC on households and public budgets. It contributes to the development of policy frameworks in Malaysia that can address the challenges of LTC financing in an era of demographic change, increasingly challenging health outcomes, and ongoing strain on fiscal budgets.

Social Insurance

Social insurance refers to financial protection offered by the government against various types of economic risks through different programs funded by the nation's citizens. All individuals, rich or poor, are exposed to uncertainty and risk in various dimensions, most importantly: health (arising from possible illness or disability), longevity (arising from uncertainty about the time of one's death), and income (arising from unemployment or other sources of

[1] SWRC working paper series. - Kuala Lumpur, Malaysia: Social Wellbeing Research Centre, ZDB-ID 3194002-X. - Vol. WP 2025, 2

unexpected fluctuation in the income stream, such as weather shocks for farmers). Important types of social insurance mechanisms include old-age and disability pensions, unemployment insurance, and public health insurance.

Whilst private insurance can be an efficient mechanism for managing insurable risks and is able to provide highly specialized insurance products for those who can afford them; from the development perspective, the system has a number of inherent limitations. In a purely private market, increasing costs and rates of claims can drive up premiums, making it unaffordable for the average person or those who need the coverage most. The poorest and most vulnerable members of society, who are often the most exposed to risks cannot afford private insurance premiums. A purely private system would leave them completely exposed, perpetuating cycles of poverty. A social insurance system on the other hand, is based on principles of **solidarity and cross-subsidization**—the young subsidize the old, the healthy subsidize the sick, the rich subsidize the poor—to ensure a basic floor of protection for everyone.

A well-designed social insurance system is not a luxury; it is a critical piece of public infrastructure that corrects for market imperfections, protects the most vulnerable, and creates the stable and healthy society necessary for sustainable economic development to take root and flourish. In sum, while the private insurance market excels at fostering market efficiency and choice; they are not designed to solve problems of equity and social welfare.

Rights-based Approach

International conventions recommend that access to LTC should be provided through a rights-based approach. It is an enabling right for persons who experience functional impairments insofar as it helps them towards their enjoyment of other human rights.

Formally, the Universal Declaration of Human Rights posits the right to social protection in Article 22, which guarantees the right to social security. Further, article 25 recognizes the right of everyone to a standard of living adequate for the health and wellbeing of himself and of his family, including medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old-age, or other lack of livelihood in circumstances beyond his control (UN, 1948).

ILO's Social Security (Minimum Standards) Convention, 1952 (C102) establishes worldwide-agreed minimum standards for all nine branches of social security: medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit, and survivors′ benefit.

The risk of invalidity requiring care in old-age lies in the conjecture of C102's old-age benefit and invalidity benefit. While guidance from International Social Security Standards (ISSS) does explicitly outline LTC as a separate contingency, the same guiding principle in designing and implementing social protection measure can be utilized; i.e. the program introduced must be to ensure that all older persons in need of LTC can access it without suffering hardship.

A Necessity of the Times

Financial protection for LTC is important because many people underestimate their future care needs and its cost; or they mistakenly assume that LTC services are subsumed to a certain extent under the national health plans (Norton, 2016). Care's nature and costs are indeed unknown variables, such that there is no exact measure way of calculating its quantum like one would do for a normal retirement plan. Hence, it can be safely assumed that average individuals and households are unlikely to plan for and save "enough" to access the LTC services that they need without some kind of support or back-up.

The Organisation for Economic Co-operation and Development (OECD) predicts that in high-income countries, approximately 50% of older people with care needs would experience income poverty in the absence of publicly-supported LTC systems (Hashiguchi et al., 2020). The same reports find that some 90% of people with the needs for intensive caregiving would face excessively high payments in the absence of financial protection. This occurs even in countries where incomes and pensions are relatively high.

Malaysia's absence or lack of comprehensive social security provisions specifically on elderly care requires urgent attention, given its twin problems of rapid ageing trend and poor health outcomes amongst the population. While life expectancy has risen over the years, the number of years an average person spent in less-than-full health has risen as well and at a much faster speed, i.e. from 4.01 years in 2000 to 4.47 years in 2019 or 11.5% increase compared to 4.3% increase in average life expectancy within the same period.[2] These statistics confirms what we already know, which is while people are living longer, they are not necessarily healthier.

A substantial number of the elderly of the future could be suffering from long-term or chronic consequences that result from a disease, injury, or medical treatment. WHO's 2021 estimates for Malaysia's population aged 55 and above living with some form of functional impairment or disability confirmed that almost 91.2% of all the Years of Living with Disability (YLD) for males and 87.4% for females[3] are caused by the effects from noncommunicable disease (NCD) (Khalid, Mansor, 2025).

These and other trends pointing towards a higher probability of older persons developing LTC dependency, call for the strategic development of a contingency reserve at the aggregate level. A social insurance model provides a proactive, solidarity-based approach to managing ageing societies' needs. The LTC benefit program sits well in the life-cycle approach to social protection, which aims to respond to the needs of individuals throughout different stages of their lives, from childhood to old age.

The rest of the paper discusses recommendations regarding various elements of a potential LTC benefit program for Malaysia.

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[2] HALE represents the expected number of remaining years of life spent in good health from a particular age (typically birth or 60 years), assuming the rates of mortality and morbidity remain unchanged. It is used to indicate disability-free years of an average individual in the country.

[3] Calculated using data from WHO's Global Health Estimates, 2022. Years Lost due to Disability (YLD) YLD is expressed per 100,000 population. It indicates non-fatal burden of disease and injury or in other words, the measure of healthy years lost due to ill health, and calculated by multiplying the prevalence of the disease' major sources of health loss (sequelae) to its disability weight by age group and sex.

Elements of a Social Insurance for LTC

Element 1: Coverage

Among the first key policy questions in designing and financing LTC is determining the population to be covered. Countries can choose universal or selective approaches, or a specific mix of the two, in determining which demographics will benefit from public-funded LTC social insurance coverage.

Universal LTC systems generally cover the entire population, while selective approaches tend to only focus on LTC services for those in greatest need. The latter is rooted in the development theory that social programs must be geared towards reducing inequality and poverty.

A number of countries have enshrined in their legal framework, that the right to LTC benefits must be based on **needs** rather than **means** or ability (Schön and Heap 2018). The reason for this universal approach is because the risk of requiring LTC at old-age is not evenly distributed across the rural/urban divide and income levels. LTC needs are not uniform, they can range from the very simple to very complex and difficult to anticipate the LTC will be necessary for. Hence, fees linked to utilization are inequitable and disproportionately burden those most in need of LTC. This is why experts advocate for the **development of policy solutions that decouple payments from use; where LTC is treated as a contingency risk that should be financed and managed collectively via a national insurance system**.

This underlying principle of ensuring equitable access for all of the population, based on their needs for health and social care is aligned with United Nations (UN) commitments outlined in the 2030 Agenda for Sustainable Development, specifically Target 3.8 of Sustainable Development Goal 3 that aims to achieve universal health coverage. The universal approach to LTC is also aligned with the Convention on the Rights of Persons with Disabilities, adopted by the UN General Assembly, wherein Member States committed to ensuring access to services for people with disabilities and the forthcoming UN convention on the rights of older people.

Given that Malaysia is ageing at an unprecedented rate, ensuring full i.e. universal coverage is the only way forward. The arguments for universal coverage are presented below.

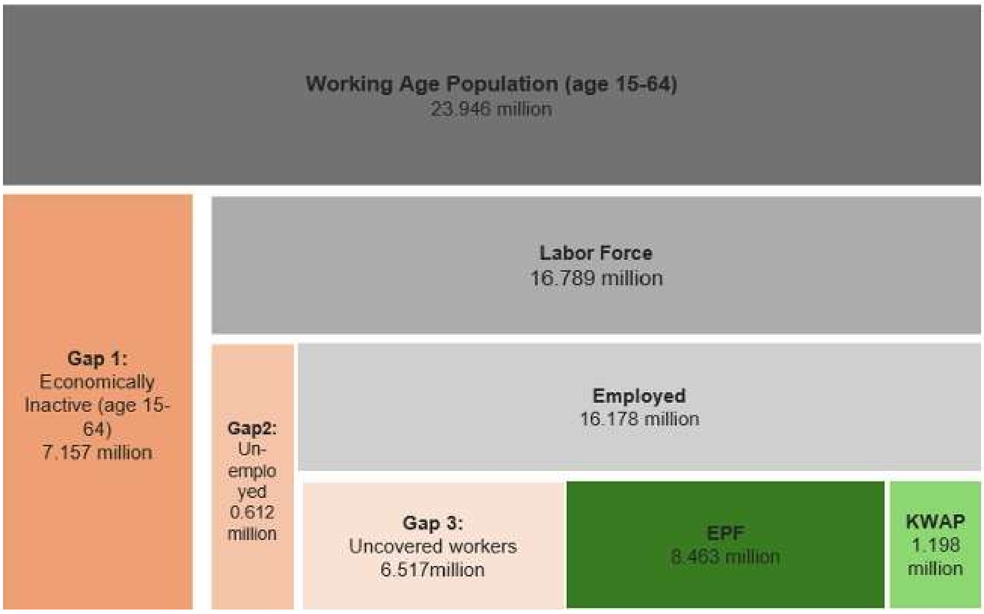
1. **Insufficient coverage of social protection**

   Social protection coverage in Malaysia prioritises two population groups at opposite ends of the income scale: (i) salaried employees in the formal sector (public servants or private sector workers), particularly those in stable full-time employment relationships and (ii) vulnerable individuals living in poverty who are able to benefit from various social assistance arrangements (Rabi et al., 2019).

   Even so, for the second category, coverage of means-tested social assistance is still low. Out of the 3.9 million individuals aged 60 and above in Malaysia in 2024, only around 154,000 (3.95%) are recipients of the Older Persons Assistance (*Bantuan Warga Emas*). The more broad-based *Sumbangan Tunai Rahmah* (STR) scheme includes a category for old persons who are single or is a single parent /widow/widower without children and whose monthly income is less than RM5,000. The estimated number of elderly persons in this category is around 1.3 million recipients. Other older persons may benefit indirectly from STR as members of a household that is earning less than RM5,000, although their presence in the family is not counted in the calculations of the full benefits value, as compared to children.

Apart from the two groups, informal groups of workers or persons in precarious forms of wage employment and the self-employed, are not covered (Gap 3 in Figure 2); as are economically inactive (Gap 1 in Figure 2) and unemployed individuals (Gap 2 in Figure 2). In the majority of the cases, they not only lack the capacity to save for old-age, even if they can, they cannot save in a consistent manner. In total, the three groups represent half of the current working-age population of Malaysia (e.g. in 2023 the number adds up to 14.3 million). Therein lies the problem. If old-age income security or pension is already not available to so many people, it follows that affording LTC costs over and above their old-age living expenses would be impossible.

Figure 1. Three coverage gaps in old-age income security in Malaysia, 2023



Source: Rabi, et al. 2024, using data from (Department of Statistics Malaysia, 2023), (UN, 2022), (EPF, 2024), and (KWAP, 2024)

2. Going Beyond Exclusion Error

Implementation of a sound means-tested program necessitates that exclusion errors must be minimal. Errors in enrolment affects the desirability of a social protection program, as it indicates that the system is poorly designed and managed.

To reduce exclusion errors, it simply requires that household’s income or asset values can be properly established. This value must then be compared against local income or wealth thresholds and household size, to determine eligibility to receive assistance. The calculation will not be straight-forward in households earning intermittent or unstable flows of income; presenting a conundrum for the government in delivering targeted social assistance programs.

In the context of LTC, it goes beyond the issue of calculating income levels fairly. There is potentially a group of ‘exclusion error’ individuals i.e., people who do not meet the minimum income thresholds but are essentially poor because of the burden of care. Working family members may be forced not to work or reduce their working hours to provide unpaid care, causing partial loss of household income.

By having to give up their old-age savings or assets and also risk spending down their children's savings, the older person or the sandwich generation family responsible for his care, may end up being economically vulnerable.

In other words, a household might only be eligible for assistance **after** they have become impoverished. Whereas even if the level of elderly disability is very high (meaning they might be spending a considerable amount of money on care), they are erroneously 'excluded' from social protection coverage because of their relatively comfortable level of income and assets.

Another reason why many elderly persons or their families might not enrol in means-tested LTC programs is the stigma tied to being a beneficiary of public assistance programs. The design and implementation of public LTC in which targeting can be administratively complex or costly, may deter middle-income households and those near the low-income threshold from applying for the needed services.

3. Implications on Inequality

A targeted or means-tested LTC benefits schemes are often favoured traditionally by developing countries due to concerns over fiscal expenditure. However, this approach has brought on grave consequences in term of inequality.

For one, means testing for the provision of LTC services leads or strengthens the development of a two-tiered system. In the first tier, public institutions (in the context of Malaysia, Department of Social Welfare) and charity-based or faith-based organizations often ends-up catering to the poorest. These service provisions are extremely inflexible and susceptible to budget cuts and poor monitoring of quality. Government-run homes for the elderly, such as *Rumah Seri Kenangan* and *Rumah Ehsan* can only focus on providing long-term accommodation to homeless or destitute elderly persons, and even then, only take in elderly persons who are physically independent and free from major medical issues (JKM).[4]

In the second-tier, private companies offer customable LTC solutions to fit the requirements in the market and where costs of private nursing homes can reach almost 4 times the minimum wage level in Malaysia. Shortage of health and personal care workers in the LTC sector means that the scarce human resource will naturally gravitate towards the private establishments and leave the public institutions under-staffed and over-burdened.

The macro and micro impacts of ignoring potential coverage gaps on inequity cannot be overemphasized. It is often assumed that the main disadvantage of the universal approach is higher costs relative to the targeted approach, since the latter is only paying for a small portion of the population. However, this assumption is only true if the universal LTC system offers a relatively generous benefits package.

[4] Info Warga Emas, accessed at https://wargaemas.jkm.gov.my/portal

The generosity of an LTC benefits package is determined by separate decisions about the scope of covered benefits, cost-sharing with beneficiaries, pricing and reimbursement policies, and quality standards. By working with a lean and flexible package, the greater the number of beneficiaries the fiscal space can allow.

This is why many countries which are early adopters of a universal LTC program such as Japan and Germany periodically review their programs in response to demands and resources. In other countries, the benefits package is constructed as lean or uses a high eligibility thresholds (which means that they only focus on the most severe disabilities or highest needs for care), co-payments for services may be high.

The choice of service delivery model is also a key determinant of the program's cost. For example, costs may be higher in systems where non-medical LTC services are delivered in health care or specialized nursing facilities. On the other hand, where home-based or community-based (shared resources) are more normalised, the cost of the program will be relatively smaller, hence able to benefit more beneficiaries.

A universal social insurance benefit program, can offer the flexibility for higher income individuals to opt-out – especially if the amount received is insignificant in relation to their care needs. In any case, the progressive income tax and the consumption-based tax system will ensure that net transfers from high-income individuals to poorer individuals are still positive and substantial.

4. LTC Coverage around the World

Universal LTC coverage is currently only available in a few countries; it is financed mainly through public social insurance (e.g., Germany, Japan, Luxembourg, the Netherlands, Republic of Korea) and/or general taxation (e.g., Denmark, Finland, Sweden, Spain). Many countries combine different approaches, offering a mix of universal and means-tested LTC services. Under mixed approaches, universal entitlement applies to some services or groups of people, whereas means testing is applied to other services. For instance, institutionalised care which is naturally more expensive compared to home or community delivered care, usually comes under the means-testing mechanism.

Thailand, for example, delivers LTC through a combination of universal allowance programs and targeted assistance. The universal community-based LTC program provides community- and home-based care for frail individuals aged 60 years and older. The program is funded in part through the country's tax-financed universal health care program. Complementing the community LTC program are two universal allowance programs: one targeting ALL adults aged 60 years or older and persons with disabilities and another, which is a means-tested assistance program for vulnerable older persons provides financial assistance and helps them secure accommodation and food. It is funded by excise taxes on products including tobacco and alcohol, and donor contributions (Aung, et al., 2020).

Element 2: Contingency

ILO recommends that each country's LTC entitlement be materialised through a clear definition of the **contingency** underlying it. ILO recommends a general criteria for entitlement, *"a significant decline in a person's capacity requiring extended care and support in order to live a life consistent with human rights and dignity*" (ILO, 2024). A country can adopt a definition that suits the objective breadth, depth and level of social protection capacity in the country. Following are several options for determining the contingency and eligibility thresholds for the Malaysian LTC.

1. Activities of Daily Living (ADL)

The most commonly used criteria in countries with LTC insurance benefit presently is the ability to perform activities of daily living (ADLs) – eating, bathing, dressing, toileting, mobility and continence (ISSA 2022). ADLs are typically divided into two categories: basic and instrumental.

- Basic ADLs (BADLs) include personal hygiene - bathing, grooming, oral care, and dressing; mobility - walking, transferring (e.g., from bed to chair), and using stairs; eating - feeding oneself; and toileting - using the toilet and maintaining continence.

- Instrumental ADLs (IADLs) include household tasks: cooking, cleaning, and laundry; managing finances: paying bills and managing money; shopping: grocery shopping and other errands, transportation: driving or using public transport; communication: using the phone or computer.

For example, in Singapore, the assessment of loss of ADL and IADL function is carried out by an assessor accredited by the Ministry of Health. To qualify for LTC benefits under the ElderShield social insurance program, the old person or person with severe disabilities must require the physical assistance of another person to perform at least three ADLs (ILO 2021b).

In Germany (Rothgang, 2010), to be eligible, the person must require help with at least two ADLs and one additional IADL for an expected period of at least six months. The assessment looks at three levels of dependence depending on how often assistance is needed and how long it takes a non-professional caregiver to help the person. Australia uses four levels of core activity limitation (CAL) - mild, moderate, severe and profound - based on whether a person needs help with, has difficulty with or uses aids or equipment for any of the core activities (communication, mobility and self-care).

While the inability to perform one or several ADLs alone is commonly used across existing LTC provisions, it is important to note that care needs may go beyond ADLs. Providing services to address IADL limitations can help people stay in their homes for as long as possible and reduce the pressures on and costs to hospitals and acute care facilities.

2. Washington Group on Disability Statistics (WG)

Taking a leaf from disability benefits, and especially with respect to measuring functional impairment, the assessment question sets developed by the Washington Group on Disability Statistics (WG) provides a reliable alternative to the ADL-based assessment methods.

The WG Set of questions on Functioning were developed based on the WHO's International Classification of Functioning, Disability, and Health (ICF) as a conceptual framework. The WG Enhanced questionnaires[5] obtain information on difficulties a person may have in up to ten domains of functioning:

1. vision
2. hearing
3. mobility
4. cognition
5. self-care
6. communication
7. affect (anxiety & depression)
8. upper body functioning
9. pain
10. fatigue

Malaysia's own Social Security Organization (PERKESO) defines the contingency that allows its insured members to receive an invalidity pension in simpler terms. The disability experienced must be permanent (either incurable or not likely to be cured and no longer capable of earning) and confirmed by a qualified doctor, even though the disability does not arise from a work-related accident or illness related to the insured member's occupation. The applicant must then be certified invalid by the Medical Board or Appellate Medical Board (if initially rejected).

However, PERKESO's Invalidity Pension, being part of an employment-based social insurance framework, does not cover individuals who have attained 60 years of age at the time an Invalidity Notice is received. Exceptions are allowed if the employee exceeded 60 years of age at the time the Invalidity Notice is received, provided he/she has evidence of a morbid condition that has set in before reaching 60 years of age and that he or she has not been gainfully employed since then.

While there are calls to increase the retirement age to 65, hence extending the PERKESO's eligibility period, this will not solve the problem for disabilities or functional impairments acquired after the retirement age. Civil servants and the non-working populations, workers in the informal economy who are PERKESO members do not have a similar recourse should they find themselves in need for rehabilitation or LTC at old age.

[5] Source: https://www.washingtongroup-disability.com

Element 3: Periodic Assessment

Ideally, the eligibility considerations for receiving a public LTC program must include a plan for periodic reassessment. This is necessary in order to accurately reflect the beneficiaries' changing needs and circumstances. Japan's Article 28 of the Long-Term Care Insurance Act requires that the periodicity of reassessment be every 12 months. However, local governments which are put in charge of receiving and approving applications for the LTC benefits can choose to amend this time range to be anywhere between 3 and 48 months (Tessier et al. 2022).

A periodic assessment framework requires that there is a nationally standardised, objective, and fair needs-assessment system that is scientific, transparent and acceptable to every citizen. Due to the potentially large number of applications, the task cannot be burdened on medical and welfare professionals entirely.

In Japan, local governments send care needs assessors for extensive training, before they can be deployed to carry out the assessment, which must be done at the applicants' homes. To ensure fairness, the Japanese system of LTC assessment employs certain principles:

- Use of standardised instrument, such that any trained investigator should obtain sufficiently similar results for the same applicant
- Results should be strictly based on the response to the assessment questionnaire, and not other factors
- Needs should be expressed in the standardised measurement units.
- The applicant's income, assets and availability of family care have no bearing on the assessment because entitlement conditions are based strictly on the physical and mental status of the applicant.

The approved beneficiary's level of required care (classified as Preventative Support Level 1 or 2, or Long-term Care Level 1 through 5) is then determined by a committee of specialists who takes into consideration results from the on-site survey report.

On the other hand, PERKESO's model for Invalidity Pension assessment relies on a single assessment at the start of the application. While this is clearly advantageous in terms of administrative burden and hassle for the beneficiaries, it can also mean that very few applicants will be able to cross the high threshold set and be eligible for the lifetime pension.

It is recommended that for the proposed Malaysia's LTC program, a periodic reassessment condition to be put in place. Intuitively, a system that is based on periodical reassessments allows beneficiaries to 'move out' of the benefit's registry when their condition improves or when an alternative care-giving options (and funding source) becomes available. This in turn can help save the government some funds in the long run. A reassessment period of say 3 to 4 years will also reduce the risk of fraud cases where people commit insurance fraud e.g. continuing to collect LTC benefits of recipients who have already passed.[6]

[6] In a news article dated 4 Jun 2025, Human Resources Minister Steven Sim said that PERKESO investigated close to 1,200 suspected fraud cases with various schemes involving long-term funds of over RM60.84mil. https://www.thestar.com.my/news/nation/2025/06/04/perkeso-fraud-probe-saves-over-rm48mil

Element 4: Benefits

The scope of benefits - what is needed and what is covered - in a care-based context will be naturally wide, hence it is important for a public LTC benefit package to be determined appropriately based on robust quantitative techniques and qualitative considerations e.g. hardship, availability of caregiver etc.

In reality, either benefits in cash or in kind or a mix of both can be offered. Benefits in-kind are typically health and personal care services needed to preserve health, prevent further loss of function, conduct activities of daily living, support independent living and foster participation in social activities. Cash benefits can take different forms, such as cash to the person in need of LTC to cover the costs of accessing goods and services not directly provided in kind, direct payment to caretakers or a subsidy for home accessibility improvements.

1. In-kind Benefits

In the Japanese LTC system, in-kind care benefits can be accessed through facility-, home- or community-based services, as can preventative LTC services; depending on the level of care needed (Yamada and Arai 2020). Sweden's LTC benefits package includes: Home-Based Care (*Hemservice*), Assisted Living Facilities (*Servicehus*), Nursing Homes (*Särskilda Boenden*), Respite Care (*Anhörigomsorg*), and Day Care Centers (*Dagverksamhet*).

In a benefits-in-kind system, the role of regulators and their effectiveness will be extremely critical. They are responsible for ensuring that a dedicated and well-regulated network of service providers is always performing at or beyond the standards of minimum care service delivery. This is indeed the main cornerstone of the LTC insurance systems in Japan and South Korea (Yamada and Arai, 2020). Care providers approved to be part of the program must meet very strict conditions on quality of physical infrastructure, quality of care services, accessibility and governance, in order to be allowed to renew their license and participate in the government LTC program.

The in-kind benefits delivery network model also requires that there is a continuum of well-coordinated care services available along family, home-based social and health care, and residential care lines. This will be a particularly arduous task in a country like Malaysia where different care categories are governed by different government agencies or laws (healthcare, social care and domestic work, not to mention transportation, food and beverages etc.).

For the system to work, the range of LTC services on offer must be wide enough to meet most LTC needs (e.g. care for NCD such as stroke or diabetes complications, dementia care, psychiatric care etc.); otherwise, there will many who cannot benefit from the program if the services are too homogenous and restrictive.

Equally important, the government will need ensure that their respective supply levels must be sufficient and be available in all parts of the country. Physical or geographical difficulty of accessing LTC services is one of the reasons why families are not able to provide the right standard and amount of care for their elderly loved ones.

The existence of weak legal frameworks to contract and monitor all the different types of care delivery actors limits the feasibility of in-kind benefits in most countries (Bannenberg et al.

2019). Because of this and the lack of breadth and depth in the private LTC market, **Malaysia would do well to consider adopting the cash benefits model, until a time where all the pre-conditions for an in-kind system are established.**

2. Cash Benefits

The cash received by beneficiaries can be used to purchase needed LTC services – whether personal, health or medical – from either professional or informal caregivers (their own family members or hired domestic help). The flexibility accorded by the use of cash, in the current state of LTC services overrides the common concerns people have with giving cash to beneficiaries.

Cash benefits enable choice and allow beneficiaries to purchase the nursing and personal care or any assistive device that they need including enabling them to stay in their home. It is also effective in reducing reliance on institutional care, since cash benefits are often small, relative to costs of nursing homes. This will be in line with the desire of most elderly persons to age in-place and what the government should prioritize on in managing elderly LTC in Malaysia. The aim of the LTC cash benefit system will be to encourage a wide range of care delivery options:

1. In-Home Care: Family members, Home Health Aides, Skilled Nursing Care, Companion Services, Adult Day Care
2. Assisted Living Facilities
3. Nursing Homes
4. Memory Care Units - Specialised care for elderly individuals with dementia or Alzheimer's disease.

In all of the options above, any shortfall of costs will have to be covered through Out-of-Pocket payments or government/charity means-tested programs for support.

To enable LTC at home, the cash benefits can be used to pay for various types of support that can help the elderly person and their caregivers (see Table 1).

Table 1. Types of Support

Type of Support	Explanation
Occupational Therapy	Training programs that help individuals regain or adapt skills for adls
Assistive Devices	Walkers, hearing devices, grab bars, wheelchairs, reading and hearing aids, special beds, incontinence products, rollator shower chairs, lumbar corsets
Home Modifications	Ramps, stairlifts, or bathroom safety features
Caregiver Support	To pay caregivers (family member or outsider) who are on hand to assist with ADLs like bathing, dressing, and meal preparation, to provide counselling, and dementia care
Medical Interventions	Treatment of underlying conditions (e.g., physical therapy for mobility issues, nursing assistance for wound care or palliative care)

Digital Products	Software and apps that serve remote monitoring, medication reminders, Cognitive remediation and connection to emergency support

At home, a substantial amount of care work is performed on an unpaid basis. A cash-based benefit can be used to pay family members (or informal caregivers) for their time spent providing care and the losses from reduced hours of paid work and productivity. Malaysia's *Bantuan penjagaan OKU terlantar/Pesakit Kronik Terlantar (BPT)* allowance is similar in its intention, but is currently a means-tested program and has more stringent assistance thresholds.

Singapore's Central Provident Fund's (CPF) allows contributions to members healthcare savings account, Medisave, to be used to pay ElderShield premiums.[7] Both the ElderShield and Careshield Life programs provide benefits in cash in the form of monthly payments, instead of a lump sum payment, giving the insured a regular stipend to manage their LTC needs – whether to hire a caregiver, to fund rehabilitation and lifestyle alteration and others.

Coverage of the ElderShield and CareShield programs are for life once the person completes paying all the premiums at age 67 (or 10 years after joining, whichever is later). Family members can help pay premiums on a person's behalf. In addition, the government offers means-tested subsidies up to 30% of the premium, Participation Incentives and Additional Premium Support (APS) for eligible members.

3. Unintended Consequences

While the greatest advantage of the cash benefit option is flexibility and low administration burden, the system can bring in various unintended consequences. Cash-based LTC programs may result in encouraging the informal market for migrant domestic workers (as occurs in Austria, Germany and Italy) rather than generate demand for local formal services and foster professionalism in the provision of those services.

Furthermore, if the cash benefit is too small OR risk of being diverted to other household uses, the intended LTC beneficiary may end up obtaining inadequate or low-quality LTC services, resulting in suboptimal care results.

Cash benefits may also promote or perpetuate gender inequities by encouraging caregivers, who are mostly women, to remain in traditional informal caregiving roles rather than enter the formal labour force.

Hence, for the cash benefit to serve the beneficiaries well, the person must be fully aware of his LTC needs and can make the decision on how the money is to be used. If he or she is unable to decide, then a trusted family member must make the decision.

[7] CPF members save between 8% and 10.5% of their monthly salary in MediSave account. Until 2019, all Citizens and Permanent Residents with MediSave Accounts were enrolled in ElderShield at the age of 40, unless they opted out. Auto-enrolments into ElderShield were discontinued in 2020, replaced by CareShield Life.

To mitigate the known risks from the cash and in-kind benefits options, the Republic of Korea LTC scheme, for example, provides cash benefits are provided on a case-by-case basis to older persons living in remote areas with no access to in-kind benefits (Lee, 2015). The rest of the LTC system still rest largely on the in-kind benefits principle with large networks of LTC service providers and a well-regulated system of quality assurances.

Element 5: Financing

Expenditure related to LTC is expected to rise significantly in relation to the Gross Domestic Product in the coming decades (see Khalid, Mansor, 2025 on the looming care crisis in Malaysia), making its financing one of the most pressing societal challenges.

As with other social protection program, a public LTC program can be primarily financed through two methods: either through a dedicated increase in defined contribution schemes or mandatory social insurance contribution or a system based on taxes and the pay-as-you-go principle.

1. Contribution-based LTC funding

The number of persons covered through a contribution-based system would be limited mainly to salaried employees in the formal sector (public and private), particularly those in stable full-time employment relationships. A mandatory LTC insurance scheme must be kept separate from mandatory health insurance scheme. A separate program for LTC ensures that spending limits on LTC are well-protected. As such, the rate of contribution (or payroll tax rates) will have to be increased to cover both health and LTC contingencies.

The ‘coverage’ challenge to provide old-age security to individuals in Gaps 1 through 3, as discussed earlier, would apply in the context of LTC benefits. Such a system of mandatory insurance only works optimally in high-income settings where most adults are in the formal workforce. In low- and middle-income countries with a large informal workforce or low average wage, such insurance mechanisms are less feasible for extending reasonable LTC coverage to the population.

Risk of needing LTC is heavily skewed towards those in the lower income group and towards women. Those who are poor and those in ill health may have higher care needs leading to higher out-of-pocket payments, gradually amplifying the household’s poverty burden and increases inequality in society. A solidarity-based financing mechanism, such as one that is tax based, would therefore be most appropriate.

2. Tax-based LTC funding

General taxation provides a broad funding base and flexibility in covering LTC benefits, and it ensures coverage for those who are unemployed and those employed in the informal sector. Taxes can be collected from individuals (i.e. through income tax and consumption taxes) or from companies (i.e. through excise taxes). In terms of equity, taxes levied nationally and distributed throughout the country can compensate for regional differences in wealth and contribute to progressivity.

However in Malaysia, because taxes are not usually earmarked for any specific purposes and are pooled into a single government revenue account, specific-needs funding may be subject to budget cuts or reallocation when faced with fiscal pressures.

A tax-based pay-as-you-go LTC financing approach does not necessarily mean the government will have to raise taxes. It is equally important that the government embark on efforts to reprioritize expenditures. In the context of social assistance alone, a substantial amount of money can be saved by consolidating existing social protection arrangements into a coherent system. This can be done through establishing social protection floors that include LTC contingency. Cash-based social assistance received by older persons, be it BWE, BTP, *zakat* or STR, can be streamlined and simplified to be able to benefit more people and to reduce duplicity and costs of administration.

3. Sustainability

For the public LTC system to be financially sustainable, it is unlikely that we can eliminate out-of-pocket costs. Inflation, service variability, and individual needs necessitate co-payments (through private insurance or household out-of-pocket payments). Needs of individuals differ and the cost of care services will be affected by supply availability, transportation, maintenance and repair of products, etc. just as other types of retail services and products.

Japan's LTC insurance model shows how a mix of intergenerational transfer and self-contribution is used to support the costs of its public LTC program. Around 50% of total revenues for their LTC program are from mandatory insurance premiums contributed equally by the secondary and primary insured population groups of working age (40 64 years) and older (≥ 65 years), respectively. The other 50% is covered by consumption taxes (Cheng et al., 2023). Despite this, the co-payment requirement is still in place and in most cases in assisted living facilities, room and board costs must be paid separately by the residents themselves.

Decision on financing the LTC program must be made in cognizance of trends in other categories of social expenditures, especially for health sector. Poor or insufficient LTC availability has negative implications on the already overstretched public health system. If more elderly persons dependent of care can access LTC services at home, this contributes to lowering excessive hospitalisations (including 'social hospitalisations') as well as preventable hospitalisations due to accidents or improper care at home. Saved resources (human and physical) can be diverted to medical and acute care services. This suggests that national health expenditures may be reduced to some extent by increasing the availability of LTC, palliative care and other LTC needs that correspond to individual and family preferences (Orlovic et al., 2017).

Conclusion

Malaysia faces escalating unmet LTC needs driven by rapid population ageing, shrinking informal caregiving capacity, and strained household resources. Without robust financial protection, older persons risk impoverishment due to catastrophic LTC costs, while gender inequalities deepen as women disproportionately shoulder unpaid care burdens.

To address this crisis, Malaysia must fundamentally reconceptualise LTC: **from targeted social assistance for the poor to a universal right based on care needs**, accessible across all income groups. Concurrently, service delivery should evolve **beyond nonprofit or state welfare providers toward a competitive market prioritising consumer choice and quality**. Implementing a social insurance model — pooling risks and resources nationally—would ensure equitable access, mitigate fiscal pressures on families and hospitals, and uphold the dignity of ageing populations through a rights-based framework.

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