Data Collection Survey on Population Aging in Malaysia

Final Report

February 2014

Japan International Cooperation Agency (JICA)

Mitsubishi UFJ Research and Consulting Co.Ltd.

HM
JR
14－013

Table of Contents

Abbreviations and Acronyms

ADB	Asian Development Bank
ADFM	Alzheimer's Disease Foundation Malaysia
ADL	Activities of Daily Living
AusAID	Australian Government Overseas Aid Program
CCT	Conditional Cash Transfer
CWC	Central Welfare Council of Malaysia ／ Majlis Pusat Kebajikan Semenanjung Malaysia
DRG	Diagnosis Related Group
DOS	Department of Statistics
DWEN	National Action and Plan for Elderly／Dasar Dan Pelan tindakan Warga Emas Negara
EEP	Economic Empowerment Program
E-Kasih	E-Kasih
EPF／ KWSP	Employee Provident Fund／ Kumpulan Wang Simpanan Pekerja
EPU	Economic Planning Unit
FDTCP	Federal Department of Town and Country Planning Peninsular Malaysia
FFS	Fee For Service
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GTP	Government Transformation Programme
HHS	Home Help Service
HMP	Housing Maintenance Programme
IADL	Instrumental Activities of Daily Living
ICT	Information and Communication Technology
ICU／JPM	Implementation Coordination Unit ／ Jabatan Perdana Menteri
ILO	International Labour Organization
JETRO	Japan External Trade Organization
JKM	Social Welfare Department of Malaysia
JPA	Public Service Department of Malaysia／ Jabatan Perkhidmatan Awam Malaysia
KPI	Key Performance Indicator
KRAs	Key Result Areas
LIAM	Life Insurance Association of Malaysia ／ Persatuan Insurans Hayat Malaysia
IRBM	Inland Revenue Board of Malaysia
MBOSI	Malaysia Blue Ocean Strategy Institute
MKRAs	Ministerial Key Result Areas
MNBOS／NBOS	Malaysia National Blue Ocean Strategy
MOH／KKM	Ministry of Health／ Kementerian Kesihatan Malaysia
MOHR	Minister of Human Resource
MOU	Memorandum of Understanding
MS	Malaysia Standard
MWFCD／KPWKM	Ministry of Women, Family & Community Development／ Kementerian Pembangunan Wanita, Keluarga dan Masyarakat
NACCO	National Advisory and Consultative Council for Older Persons

NACSCOM	National Council of Senior Citizens Organizations Malaysia
NCWSDM ／ MAKPEM	National Council of Welfare and Social Development Malaysia
NEM	New Economic Model
NHS	National Health Service
NIAM	National Insurance Association of Malaysia／Persatuan Insurance Kebangsaan Malaysia
NKRAs	National Key Result Areas
1 Malaysia	One Malaysia／Satu Malaysia
PAWE	Senior Citizen Activity Centre／Pusat Aktiviti Warga Emas
PEMANDU	Performance Management and Delivery Unit
PPR／PHP	People's Housing Programme
QOL	Quality of Life
RE	Home for Chronically ill／Ehsan Home
RSK	Elderly Home／Seri Kenangan Home
RV	Retirement Village
SOCSO／PERKESO	Social Security Organization／ Pertubuhan Keselammatan Sosial
SPNB	Syarikat Perumahan Negara Berhad
SPP	Housing Loan Scheme
10 MP	10th Malaysia Plan
TWG	Technical Working Groups
UBBL	Uniform Building By Laws
UC	Universal Coverage
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UPM	University Putra Malaysia
UPWE	Elderly Caring Unit
USIAMAS	Golden Age Welfare Association Malaysia／Persatauan Kebajikan Usiamas Malaysia
U3A	University of The Third Age
Wawasan 2020	Vison 2020／Wawasan 2020
WB	World Bank
WHO	World Health Organization

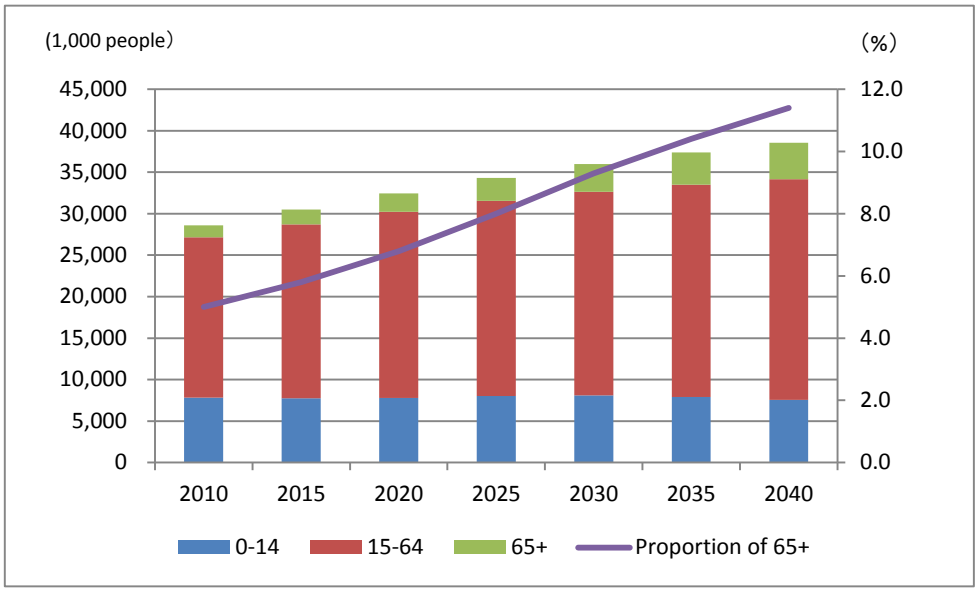
1. Current State of Population Aging

1.1. Background to the Need for Countermeasures to Population Aging

(1) Falling birthrate and aging population

The elderly population of Malaysia is gradually increasing. The proportion of the elderly population (the population aged 65 or older) among the total population (about 28.33 million as of 2010) was 5.1% (1.425 million) in 2010.[1] Additionally, in 2005 the average life expectancy of Malaysians was 76.2 years for women and 71.5 years for men.[2] By 2030, Malaysia is expected to become an aging society with the population aged 60 and above to reach 15%.[3] Figure 1-1gives population projections made by the Malaysian Department of Statistics. According to these projections, the declining birthrate and growing proportion of elderly people will proceed, with the 14 and under population and the 65 and over population, which are now at 27.4% and 5% respectively, expected to become 19.6% and 11.4% respectively, by 2040.

Factors behind this include the increase in life expectancy, declining fertility rates, the popularization of higher education for women, a tendency for women to marry later, entry of women into the workforce, a trend toward nuclear families, and the weakening role of family functions. In particular, the trend of birthrate decline is picking up speed, with the birthrate having fallen from 6.2% in 1960 to 2.3% in 2005.[4] In view of these developments, further assistance for the elderly will be needed in the time to come.



Source: Created from Department of Statistics (2012), *Population Projections*, p.2
http://www.statistics.gov.my/portal/download_Population/files/population_projections/Population_Projection_2010-2040.pdf (accessed 15 October, 2013)

Figure 1-1 Population Projections by Age Group and Proportion of People Aged 65 and Above in the Population (2010-2040)

[1] Department of Statistics, Malaysia (2010). "Population Distribution and Basic Demographic Characteristics". p.11.
[2] Tengku Aizan Hamid (2012). "Population Ageing: Past, Present and Future Trends," *Profile of Older Malaysians Current and Future Challenges.* p.8.
[3] Suhaimi Abd Samad, Halimah Awang and Norma Mansor, University of Malaysia, "Population Ageing and Social Protection in Malaysia". p.6.
[4] Hamid (2012). "Population Ageing: Past, Present and Future Trends". p.7.

With regard to the population aging rate by ethnic group, statistics reveal that population aging has progressed the most among the ethnic Chinese, 13.7% of whom are elderly. The aging rates for Ethnic Malays and Indians are 7.2% and 8.1% respectively (Table 1-1). With regard to gender ratios of the elderly as well, the majority of the elderly are women, especially in the 85+ group, which is 62.7% women (Table 1-2).

Table 1-1 Population Aging Rates by Ethnic Group (2009)

Age Group	Malay (69% of population)	Chinese (23%)	Indian (8%)	Other (1%)
0-6	13.6%	7.9%	10.0%	19.9%
7-11	11.8%	8.5%	9.6%	13.4%
12-17	16.1%	13.2%	14.5%	18.7%
18-59	51.4%	56.7%	57.9%	42.8%
60-74	5.9%	11.2%	6.5%	3.1%
75-84	1.1%	2.1%	1.2%	1.9%
85+	0.2%	0.5%	0.3%	0.3%
Total	100%	100%	100%	100%
60+	7.2%	13.7%	8.1%	5.3%

Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.5.

Table 1-2 Proportion of Women Among the Elderly (2009)

Age Group	Women
60-74	50.9%
75-84	54.7%
85+	62.7%
60+	51.9%

Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.5.

(2) Trend toward the nuclear family

A great deal of cross-generational assistance for the elderly, especially assistance from family members who live with them, is still being carried out in Malaysia.[5] Table 1-3 shows the structure of households with elderly members. In over 70%, an adult of working age is living with and supporting the elderly member.[6] However, it has been pointed out that there is a possibility that changes in family structure in Malaysia in recent years has an impact on assistance for the elderly.[7] There is a trend toward nuclear families in Malaysia, with the proportion of nuclear family households among all households rising from 30.6% to 37.6% from 1991 to 2000.[8] Moreover, the proportion of nuclear family households among households

[5] Tengku Aizan Hamid, Husna Sulaiman and Siti Farra Zillah Abdullah (2012). "Emerging Issues and Future Challenges," *Profile of Older Malaysians Current and Future Challenges.* pp.330.
[6] World Bank (2012), *Malaysia Elderly Protection Study*, p.6.
[7] Hamid, Sulaiman and Abdullah (2012). "Emerging Issues and Future Challenges". p.330.
[8] Hamid (2012). "Population Ageing: Past, Present and Future Trends". p.27.

including a person of 60 years of age or older was about 40% or more as of 2008.[9] There are concerns that from now on, due to the advance of the trend toward nuclear families, assistance for the elderly will tend to decrease and the elderly will become isolated as more and more of them live separately from their children and other relatives.

Table 1-3 Structure of Households That Have Elderly Members (2009)

	1 elderly member	2 elderly members	3 or more elderly members	Total
Only elderly	6.9%	15.9%	0.7%	23.5%
Elderly and child	0.9%	2.2%	0.1%	3.2%
Elderly and working age adult	19%	15.5%	0.8%	35.1%
Elderly, working age adult, and child	22.7%	14.6%	0.9%	38.2%
Total	49.4%	48.1%	2.5%	100.0%

Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.6.

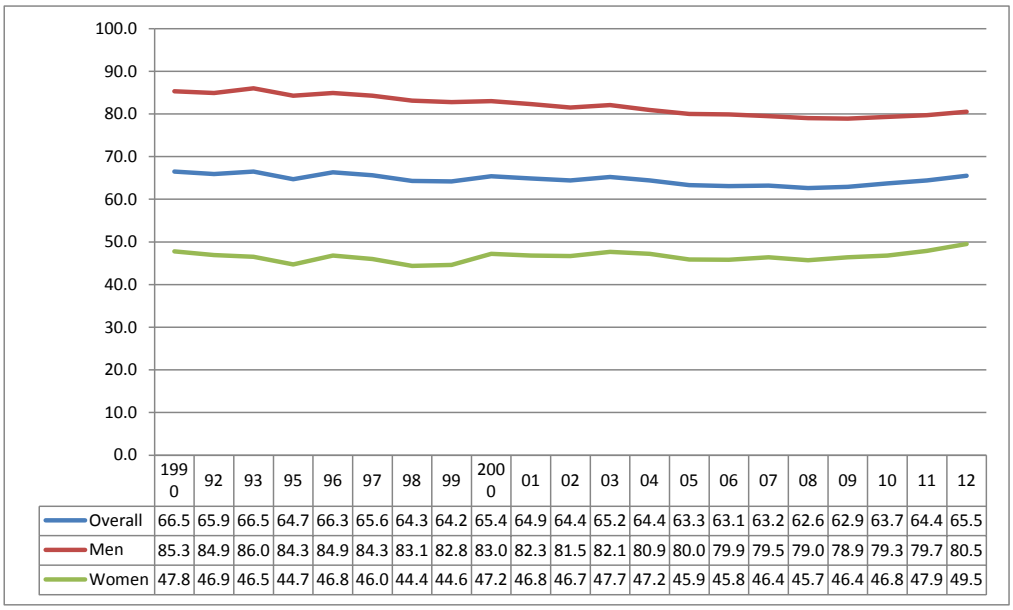
(3) Women's social advancement

Family members and relatives account for 65% of income assistance for those aged 60 or older.[10] This is because in ethnic Malay society, people have a deep sense that the family protects the home, and the Malay culture is firmly rooted in the ideas that people rely on their children in old age and that children respect their parents.[11] However, as Malaysia continues its industrialization, family roles are changing and opportunities for women to work outside the home are increasing.

Figure 1-2 shows fluctuations in the workforce participation rate from 1990. Although the female participation rate has stayed at roughly the same level, the year 2012 saw a record level of participation by women in the workforce. In Figure 1-3, we can see that the advance of women into society is progressing. Although the numbers of both men and women in the workforce are increasing, compared to the statistics for 1982, the male workforce population has increased 2.4 times, while the same for females has increased 2.6 times.

As social advancement progresses for women, who have traditionally taken the role of giving assistance to the bedridden and weak elderly, the need for assistance from not only family and community, but also from central and local governments, is expected to continue to increase.

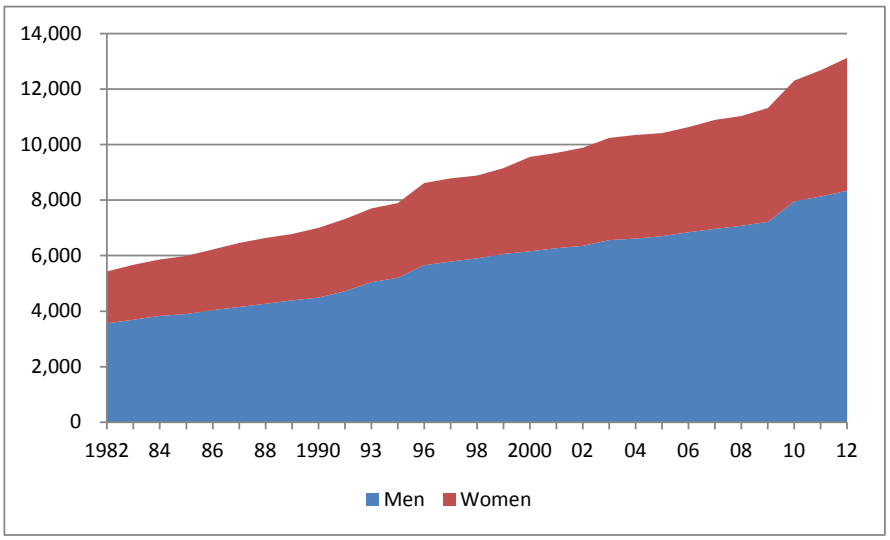
[9] Tengku Aizan Hamid, University Putra Malaysia (2012). "Meeting the Needs of Older Malaysians: Expansion, Diversification & Multi-sector Collaboration". p.9.
[10] Hamid. "Meeting the Needs of Older Malaysians: Expansion, Diversification & Multi-sector Collaboration". p.24.
[11] Kounami, Sachiko (2006). "Mareishia ni okeru koureishafukushi [The Elderly Welfare in Malaysia]", *Iryoufukushikenkyu [Journal of Medical Welfare]*, No. 2, p.12.



	1990	92	93	95	96	97	98	99	2000	01	02	03	04	05	06	07	08	09	10	11	12
Overall	66.5	65.9	66.5	64.7	66.3	65.6	64.3	64.2	65.4	64.9	64.4	65.2	64.4	63.3	63.1	63.2	62.6	62.9	63.7	64.4	65.5
Men	85.3	84.9	86.0	84.3	84.9	84.3	83.1	82.8	83.0	82.3	81.5	82.1	80.9	80.0	79.9	79.5	79.0	78.9	79.3	79.7	80.5
Women	47.8	46.9	46.5	44.7	46.8	46.0	44.4	44.6	47.2	46.8	46.7	47.7	47.2	45.9	45.8	46.4	45.7	46.4	46.8	47.9	49.5

Source: Prepared from Department of Statistics (2013), *Labour Force Survey Report*, p.241.
http://www.statistics.gov.my/portal/download_Labour/files/labour_force/Labour_Force_Survey_Report_Malaysia_2012.pdf (accessed 15 October, 2013)

Figure 1-2 Fluctuations in Workforce Participation Rate (1990-2012)



Source: Prepared from Department of Statistics (2013), *Labour Force Survey Report*, p.241.
http://www.statistics.gov.my/portal/download_Labour/files/labour_force/Labour_Force_Survey_Report_Malaysia_2012.pdf (accessed 15 October, 2013)

Figure 1-3 Fluctuations in Workforce Population (1982-2012) (1,000 people)

1.2. Basic Indicators for the Elderly

(1) Economic status

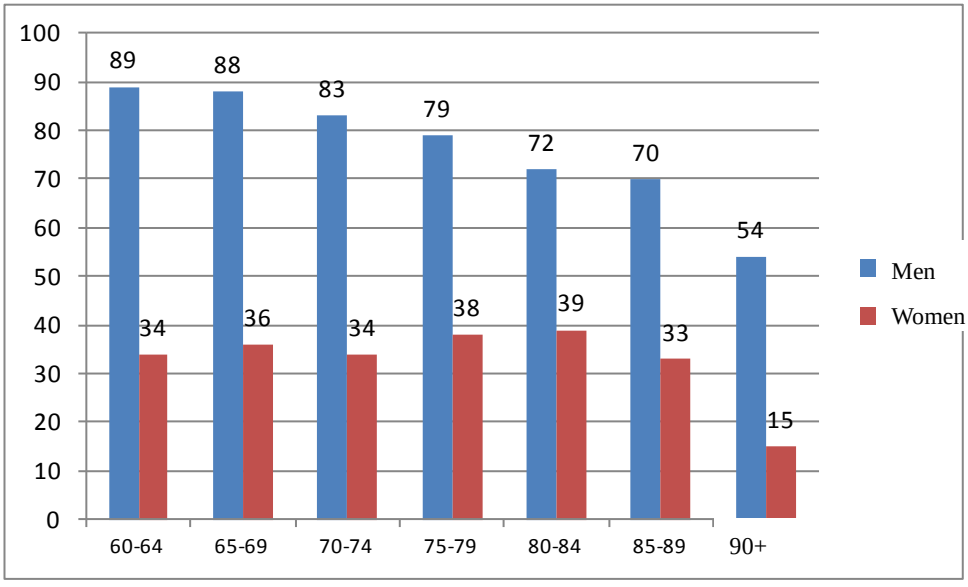
According to a survey of 2,327 people aged from 55-75 carried out in 2004-2005, income sources for

the elderly can be divided into three groups: income from work (including compensation for work for hire, salary, and pension), saving for one's old age and profit from investments (including EPF (Employment Provident Fund), other social insurance, and return on investment), and living assistance from family or relatives.[12] The average income was 6,610.88 Malaysian ringgit[13] (hereafter "MYR") (8,783.68 MYR for men and 4,229.93 MYR for women). The income breakdown was 6,903.32 MYR from work, 6,331.24 MYR from investment profits, and 2,749.42 MYR from living assistance.[14] Considering that "poverty income" (the minimum level of income deemed necessary for maintaining a living) is 6,348.00 MYR, one can see that it is easy for elderly Malaysians to fall into poverty.[15]

A look at the proportion of the elderly who have personal income reveals significant gender disparities. While over 70% of men aged 85-89 have their own sources of income, only 30% to just fewer than 40% of women do(Figure 1-4).

Figure 1-5 and Figure 1-6 give breakdowns of income sources for men and women. At the ages of 60-64, 26% of men have income from wages and 44% of men have self-employment income. Conversely, these figures are respectively 13% and 33% for women, who have a higher reliance on transfer income than income from work.

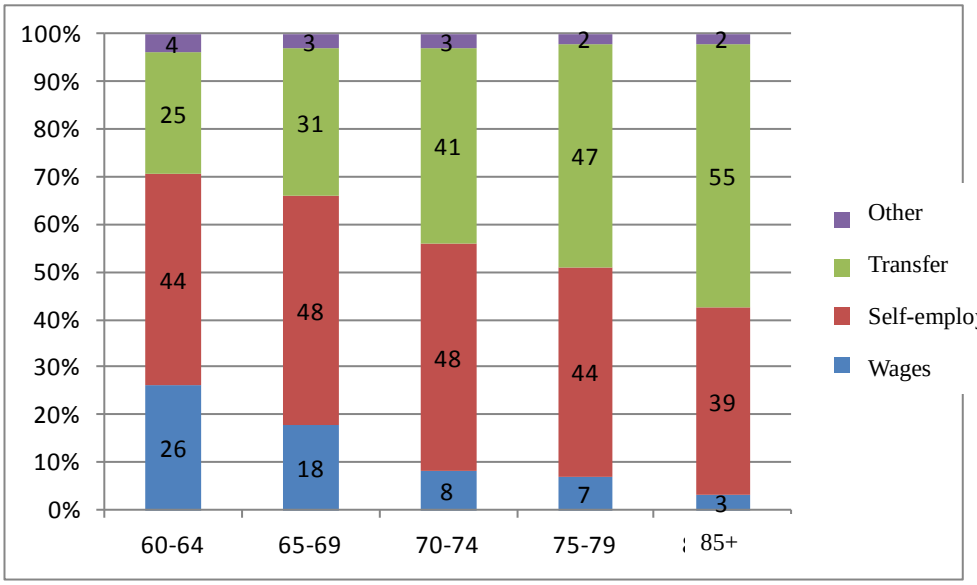
The existence of income from work is an important factor. Compared to elderly who have income from work, the majority of the elderly who have no income from work suffer from poverty.[16] Even elderly with no income from work can get out of poverty by living with their families.[17]



Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.12.

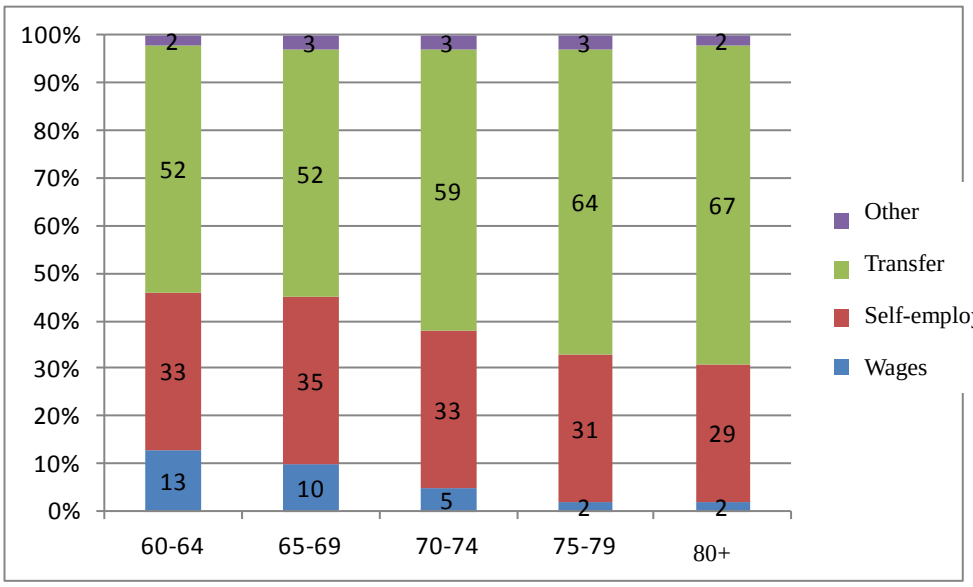
Figure 1-4 Proportion of Elderly with Personal Income (2009)

[12] Jariah Masud and Sharifah Azizah Haron (2012). "Gender Differences in Economic Status of Older Malaysians," *Profile of Older Malaysians Current and Future Challenges.* University Putra Malaysia Press, p.63-65.
[13] 1 ringgit (MYR) = 31.759 yen (referring to JICA January 2013 adjusted rate)
[14] Masud and Haron (2012). "Gender Differences in Economic Status of Older Malaysians". p.66.
[15] Masud and Haron (2012). "Gender Differences in Economic Status of Older Malaysians". p.66.
[16] Masud and Haron (2012). "Gender Differences in Economic Status of Older Malaysians". p.76.
[17] Masud and Haron (2012). "Gender Differences in Economic Status of Older Malaysians". p.76.



Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.11.

Figure 1-5 Men's Income Structure (%) (2009)



Source: World Bank (2012), Malaysia Elderly Protection Study, p.11

Figure 1-6 Women's Income Structure (%) (2009)

As shown in Table 1-4 and Table 1-5, transfer income is an important income source for the elderly. In particular, transfer income accounts for 50% or more of income for both men and women over the age of 80. Transfer income breaks down into the following types: remittances, scholarships, pensions, periodic payments, and gifts/charitable payments/in-kind. According to a World Bank report, 77% of elderly men and 33% of elderly women are receiving some kind of transfer income.[18]

[18] World Bank (2012), *Malaysia Elderly Protection Study*, p.13

Table 1-4 Proportions of Transfer Income (2009)

Age Group	Remittances	Scholarships	Pensions	Periodic Payments	Gifts/Charitable Payments/In-Kind
Men					
60-64	36%	2%	21%	6%	73%
65-69	44%	1%	19%	7%	70%
70-74	48%	1%	18%	7%	64%
75-79	46%	--	19%	7%	59%
80+	47%	--	12%	11%	55%
Women					
60-64	17%	--	7%	4%	25%
65-69	22%	--	7%	5%	29%
70-74	24%	--	7%	7%	29%
75-79	25%	--	6%	10%	33%
80+	22%	--	3%	9%	26%

Source: World Bank (2012), *Malaysia Elderly Protection Study,* p.14

Table 1-5 Average Income of Elderly By Household Structure

	MYR/Monthly Income	Proportion of Whole
All Elderly	863	100
Position in Household		
Cohabiter	131	15
Female spouse of head of household	166	19
Male head of household	1,662	193
Household Type		
Elderly and working age member	875	101
Elderly, working age member, and children	631	73
Elderly only	941	109
(Elderly and children)	(902)	(105)

Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.15

Table 1-6 shows the poverty rate in 2009. The poverty rates for households that include elderly people are actually lower than for other households. While the poverty and food poverty (hardcore poor) rates in Malaysia on the whole were 3.8% and 0.7% respectively, the same for households with only elderly were 0.7% and 0.2% respectively. The same figures for households with working age and elderly members were 1.6% and 1.0%, respectively, while both figures were 1% for households with elderly and children. All of these numbers were below the national average. In contrast, the poverty and food poverty (hardcore poor) rates of households with working age, child, and elderly members were 19.9% and 21.9% respectively, a markedly high poverty rate among households that include elderly.

Table 1-6 Poverty Rate by Household Structure (%) (2009)

	Poverty Rate	Food Poverty (Hardcore Poor) Rate
Malaysia Overall	3.8	0.7
Working age only	0.7	0.5
Child only	0.1	0.1
Working age and child	76.1	75.2
Working age and elderly	1.6	1.0
Working age, child and elderly	19.9	21.8
Elderly only	0.7	0.2
Elderly and child	1.0	1.0
Total	100	100

Source: World Bank (2012), *Malaysia Elderly Protection Study*, p.18

Table 1-7 gives comparisons of poverty status between households with and without an elderly member by region, residential area, and ethnic group. For all region-specific and residential area-specific items, households with an elderly member had lower or similar poverty rate levels. In farming villages in particular, the poverty rate of households with an elderly person was considerably lower than that of households without one.

On the other hand, indicators by ethnic group reveals that, excluding other ethnic groups, in the case of Malays, Chinese, and Indians, the poverty rates of households with and without an elderly member were about the same or slightly higher for households with an elderly member. In the case of Indians in particular, the poverty rates of households with and without an elderly member exhibited a difference that was wider than that in the other two ethnic groups, at 2.3% and 2.9%, respectively.

Poverty rate also rises in proportion to age, and one could argue that the older the person, the more economically vulnerable he or she is. (Table 1-8).

Table 1-7 Poverty Rates of Households That Include An Elderly Person (By Region, Residential Area, And Ethnic Group (2009)

With/Without Elderly Person	Poverty Rate	Food Poverty (Hardcore Poor) Rate
Malaysia Overall		
Without	3.9%	0.8%
With	3.5%	0.7%
By Region		
Peninsular Malaysia		
Without	2.1%	0.3%

With/Without Elderly Person	Poverty Rate	Food Poverty (Hardcore Poor) Rate
With	2.0%	0.3%
Sabah and Labuan		
Without	19.8%	4.9%
With	19.5%	4.4%
Sarawak		
Without	5.4%	1.1%
With	5.0%	0.8%
By Residential Area		
Urban		
Without	1.8%	0.3%
With	1.4%	0.2%
Farming Villages		
Without	9.2%	2.0%
With	6.7%	1.3%
By Ethnic Group		
Malay		
Without	5.3%	1.1%
With	5.3%	1.0%
Chinese		
Without	0.5%	0.1%
With	0.6%	0.1%
Indian		
Without	2.3%	0.3%
With	2.9%	0.3%
Other		
Without	7.0%	1.7%
With	5.6%	0.0%

Source: World Bank (2012), *Malaysia Elderly Protection Study,* p.20

Table 1-8 Poverty Rate by Age Group (%) (2009)

	60-64	65-69	70-74	75-79	80+
Men	2.2	3.7	3.4	4.8	6.1
Women	2.9	3.3	4.5	4.3	5.1

Source: World Bank (2012), Malaysia Elderly Protection Study, p.21

Table 1-9 shows the structure of household expenditure by age group of head of household. Expenditure for food and non-alcoholic beverages and housing water, electricity, gas and other fuels accounts for a large part of the total expenditure in every area of residence. Both expenditure groups account for a larger part of the total expenditure in households where the age of householder is more than 65years old, compared with other age groups. On the other hand, the proportion of expenditure of age group 65 and above for transport, communication, and restaurants and hotels is equal or lower compared with other age groups.

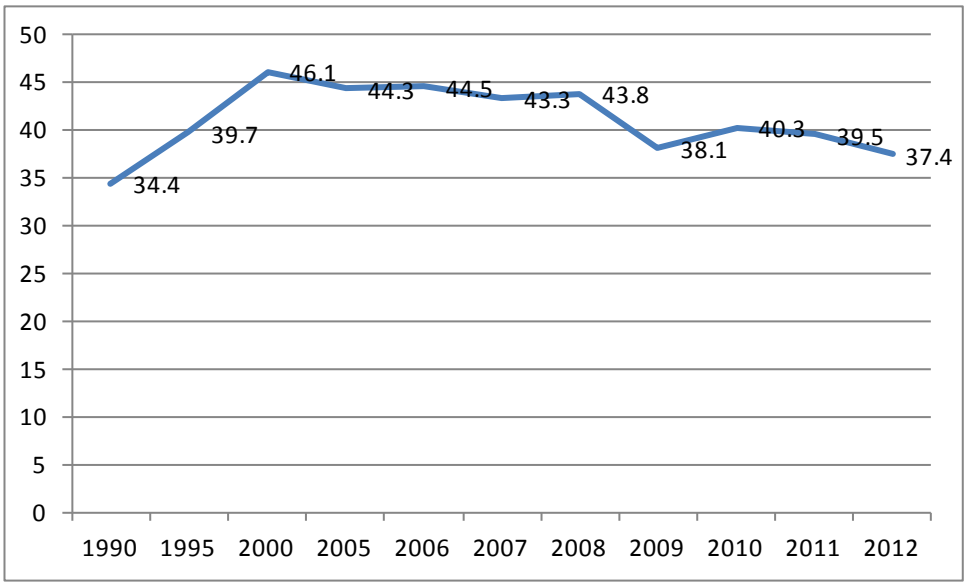
Table 1-9 Average monthly expenditure per household by age group of head of household (2009-2010)

Malaysia										
Expenditure group	24 and below		25-34		35-44		45-64		65 and above	
	MYR	%	MYR	%	MYR	%	MYR	%	MYR	%
Food and non-alcoholic beverages	251	15.5	382	18.2	453	19.6	496	21.2	403	24.4
Alcoholic beverages and tobacco	55	3.4	52	2.5	49	2.1	48	2.0	30	1.8
Clothing and footwear	58	3.6	70	3.4	78	3.4	79	3.4	63	3.8
Housing, water, electricity, gas and other fuels	387	23.8	484	23.1	505	21.9	518	22.1	435	26.3
Furnishings, household equipment and routine household maintenance	45	2.8	93	4.5	106	4.6	85	3.7	67	4.1
Health	13	0.8	24	1.1	25	1.1	33	1.4	38	2.3
Transport	186	11.5	321	15.3	353	15.3	358	15.3	193	11.7
Communication	127	7.8	124	5.9	125	5.4	133	5.7	79	4.8
Recreation services and culture	61	3.8	91	4.3	107	4.6	112	4.8	71	4.3
Education	25	1.5	15	0.7	45	1.9	36	1.5	9	0.5
Restaurants and hotels	300	18.5	259	12.4	250	10.8	235	10.0	160	9.7
Miscellaneous goods and services	115	7.1	182	8.7	214	9.3	205	8.8	106	6.4
Average monthly expenditure per household (01-12)	1,623	100.0	2,096	100.0	2,310	100.0	2,338	100.0	1,655	100.0
Urban										
Expenditure group	24 and below		25-34		35-44		45-64		65 and above	
	MYR	%	MYR	%	MYR	%	MYR	%	MYR	%
Food and non-alcoholic beverages	247	13.6	380	16.5	461	17.6	497	19.0	425	21.5
Alcoholic beverages and tobacco	59	3.3	56	2.4	54	2.1	50	1.9	33	1.7
Clothing and footwear	62	3.4	75	3.2	84	3.2	84	3.2	54	2.7
Housing, water, electricity, gas and other fuels	444	24.5	560	24.3	595	22.8	607	23.2	559	28.3
Furnishings, household equipment and routine household maintenance	50	2.7	103	4.5	123	4.7	93	3.6	81	4.1
Health	16	0.9	26	1.1	29	1.1	38	1.5	51	2.6
Transport	207	11.4	336	14.6	389	14.9	398	15.2	225	11.4
Communication	148	8.1	142	6.1	150	5.7	158	6.0	103	5.2
Recreation services and culture	72	4.0	105	4.5	131	5.0	133	5.1	94	4.7
Education	32	1.8	17	0.7	56	2.1	46	1.7	12	0.6
Restaurants and hotels	357	15.9	302	10.6	296	9.2	276	8.6	205	8.5
Miscellaneous goods and services	121	6.7	204	8.9	247	9.5	234	9.0	137	6.9
Average monthly expenditure per household (01-12)	1,815	100.0	2,306	100.0	2,614	100.0	2,614	100.0	1,978	100.0
Rural										
Expenditure group	24 and below		25-34		35-44		45-64		65 and above	
	MYR	%	MYR	%	MYR	%	MYR	%	MYR	%
Food and non-alcoholic beverages	263	25.0	386	25.3	436	26.8	494	28.0	375	30.5
Alcoholic beverages and tobacco	42	4.0	39	2.6	40	2.5	43	2.4	26	2.1
Clothing and footwear	47	4.5	59	3.9	66	4.1	69	3.9	75	6.1
Housing, water, electricity, gas	216	20.6	279	18.3	302	18.6	333	18.8	271	22.0

and other fuels										
Furnishings, household equipment and routine household maintenance		2.8		4.4		4.1		3.9		4.0
Health	29	0.7	66	1.1	67	1.0	69	1.3	49	1.8
Transport	125	11.9	278	18.2	271	16.7	276	15.6	152	12.3
Communication	63	6.0	76	5.0	69	4.2	82	4.6	48	3.9
Recreation services and culture	28	2.7	54	3.5	54	3.3	69	3.9	42	3.4
Education	2	0.2	9	0.6	19	1.2	15	0.8	5	0.4
Restaurants and hotels	130	12.4	141	9.2	147	9.0	150	8.5	102	8.3
Miscellaneous goods and services	97	9.2	123	8.0	138	8.5	144	8.1	64	5.2
Average monthly expenditure per household (01-12)	1,049	100.0	1,526	100.0	1,624	100.0	1,767	100.0	1,229	100.0

Source: Department of Statistics (2011), *Report on Household Expenditure Survey*, pp.42-47.

According to the life cycle hypothesis, people work and save money when they are young and middle age, and they draw on their savings in old age. The more the population aging progresses, the more saving rates decline. Figure 1-7 shows the gross domestic savings rate of Malaysia. The gross domestic savings peaked at 46.1% in 2000, and has declined gradually since then. According to a survey about the informal sector, the savings rate of people in the informal sector was 46.6% for men and 35.9% for women in 2004-2005.[19] The main purpose of their savings is emergency preparedness, and the percentage of people who save money for their old age was only 20 % for men and 10% for women. Shortage of savings makes those in the informal sector vulnerable because the social welfare system to cover them is not developed yet in Malaysia.



Source: ADB (2013), Key Indicators for Asia and the Pacific 2013 (44th Edition), p.219.

Figure 1-7 Gross Domestic Saving, GDP ratio

[19] Masud, Jariah and Sharifah Azizah Haron (2012), "Gender Differences in Economic Status of Older Malaysians," in Hamid Tengku Azian, Husna Sulaiman, and Siti Farra Zillah Abdullah (eds), *Profile of Older Malaysians: Current and Future Challenges*, University Putra Malaysia Press, pp.75-76.

(2) Health

According to a survey carried out in 1999, 58% of communities where many elderly aged 60 and older live considered their own health to be good, while 10% of them considered it to be very good.[20] Meanwhile, as aging of the population advances, many elderly are suffering from a variety of ailments. There have been many reports citing diseases such as high blood pressure and diabetes as health problems for the elderly in Malaysia.[21] According to a 2006-2007 survey of 2,230 elderly aged 60 and over, 1,090 respondents (49%) responded that they are suffering from chronic illness.[22] In addition, 54.1% of mental illness patients are aged 60 or above, and there are also many elderly suffering from dementia and depression.[23] It appears that one of the causes of these types of health condition is insufficient access to medical care and welfare services for the elderly. These are in turn due to economic limitations, distance from medical care facilities, and a lack of knowledge among the elderly of the existence of medical care and welfare services.[24]

(3) Working

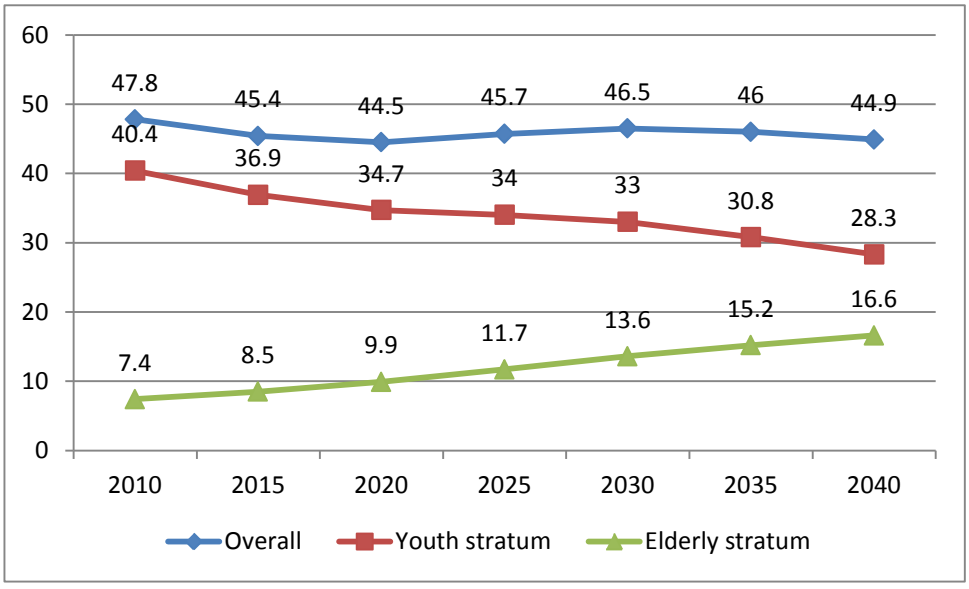
In 2002, the employment rates of age 15-64 in Malaysia were 81.5% for men and 46.7% for women.[25] Regarding elderly employment, the rate for those aged 55-64 was 4-7%. From 1988 to 2007, there was no significant change in employment rates, and no significant difference in rates between men and women. (Men 6.9%, Women 4.4% in 2002)[26] However, as the table below indicates, a disparity can be seen in workforce participation rate between men and women. On the other hand, along with the increase in the elderly population, the population of employed elderly in 2001 marked an increase of 45.3% over that of 1990.[27] Most elderly workers are working in the informal sector, and since it has no set retirement age, the population of employed elderly is expected to increase in the future.[28] Although the employed population is increasing, dependency ratio reveals that, due to the advance of the falling birthrate and aging of the population, the proportion of the elderly stratum that accounts for the dependent population is expected to increase.

[20] Ruziaton Hasim, Zaiton Ahmed, Mohmad Salleh and Tengku Aizan Hamid (2012). ”Health Issues among the Aged,” *Profile of Older Malaysians Current and Future Challenges.* University Putra Malaysia Press, p.128..
[21] Hasim, Ahmed, Salleh and Hamid (2012). ”Health Issues among the Aged”. p.130.
[22] Hasim, Ahmed, Salleh and Hamid (2012). ”Health Issues among the Aged”. p.130.
[23] Hasim, Ahmed, Salleh and Hamid (2012). ”Health Issues among the Aged”.p.133.
[24] Hasim, Ahmed, Salleh and Hamid (2012). ”Health Issues among the Aged”. p.140.
[25] Masud and Haron (2012). ”Gender Differences in Economic Status of Older Malaysians”. p.58.
[26] Masud and Haron (2012). ”Gender Differences in Economic Status of Older Malaysians”. p.59.
[27] Masud and Haron (2012). ”Gender Differences in Economic Status of Older Malaysians”. p.59.
[28] Masud and Haron (2012). ”Gender Differences in Economic Status of Older Malaysians”. p.59.

Table 1-10 Workforce Participation Rate by Age Group (2008-2012) (%)

Gender	Year	Overall	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Overall	2008	62.6	18.4	64.9	80.6	78.5	76.3	75.2	72.8	67.2	47.7	36.7
	2009	62.9	17.2	64.0	81.9	79.5	77.1	76.2	72.5	68.4	49.5	35.7
	2010	63.7	18.6	64.7	82.6	80.5	78.3	75.8	74.5	67.8	50.2	34.6
	2011	64.4	18.6	62.9	83.2	82.2	79.4	76.6	76.0	68.5	52.2	36.3
	2012	65.5	18.6	62.7	83.2	82.5	80.7	78.6	76.7	71.2	56.2	39.5
Male	2008	79.0	22.1	76.1	95.4	97.5	98.1	97.3	96.4	91.0	67.7	54.6
	2009	78.9	21.7	74.0	95.8	97.7	97.9	97.6	96.6	92.4	70.4	52.0
	2010	79.3	24.0	74.5	95.8	97.6	98.0	97.8	96.2	91.4	71.1	51.5
	2011	79.7	23.8	72.9	96.1	97.9	98.0	97.7	97.0	91.3	73.5	53.8
	2012	80.5	23.7	73.8	96.1	97.7	98.2	97.6	96.9	92.5	76.8	57.4
Female	2008	45.7	14.6	53.4	65.5	59.2	54.1	52.4	48.2	42.1	26.8	18.1
	2009	46.4	12.5	53.6	67.5	60.8	55.9	54.2	47.7	43.4	27.9	18.7
	2010	46.8	13.0	54.1	67.6	61.1	57.1	53.2	50.9	42.6	28.2	17.2
	2011	47.9	13.1	52.3	68.8	64.2	59.1	54.9	53.3	44.1	29.8	18.3
	2012	49.5	13.3	51.0	69.0	65.1	61.4	59.0	55.3	48.3	34.6	21.2

Source: Prepared from Department of Statistics (2013), *Labour Force Survey Report,* p.242.
http://www.statistics.gov.my/portal/download_Labour/files/labour_force/Labour_Force_Survey_Report_Malaysia_2012.pdf (accessed 15 October, 2013)



Source: Department of Statistics (2012), *Population Projections*, p.3.
http://www.statistics.gov.my/portal/download_Population/files/population_projections/Population_Projection_2010-2040.pdf (accessed 15 October, 2013)

Figure 1-8 Projected Dependent Population Ratios (2010-2040)

(4) Living environment

In Malaysia, relations between families are firm, but the declining birthrate and aging population, as well as the trend toward nuclear families, are progressing, and the number of households comprised only of the

elderly is increasing. Although urban areas, where 53.9% of the elderly live,[29] are equipped with infrastructure and social services for medical care, welfare, and education, access to urban areas is limited for the elderly who live in rural areas far away from the cities, due to time constraints and economic limitations.[30] Moreover, the older the age, the greater the population of female elderly, and assistance from family is especially important for women who have no income from work.[31] Along with the declining birthrate, the aging of the population, and the increase in the population of female elderly, the economic dependency rate of the elderly (65+) on the younger stratum (15-64) is about 6.3% and has been increasing year after year.[32]

(5) State of social participation

Since the life expectancy of both men (71.5 years) and women (76.2 years) in 2005 were on the increase there is no small number of elderly who are healthy even after reaching the retirement age of 60.[33] The role of supporting group activities and learning activities for these healthy elderly is being filled mostly by NGOs, foundations, and other non-profit organizations. For example, there is the University of Third Age (U3A) program carried out by the Institute of Gerontology, University Putra Malaysia (UPM), and dance and karaoke programs for elderly in local communities run by the National Council of Senior Citizens Organisations Malaysia (NASCSOM) through daycare centers.[34] Community colleges have been established throughout the country, but none of them are intended exclusively for the elderly, and lifelong learning opportunities are limited, as most programs are one-day events.[35] Those who participate in lifelong learning and group activities gain knowledge and friends, and such activities are considered to be links to improved quality of life (QOL) for the elderly.[36]

1.3. Current State of Elderly in Need of Care

(1) State of elderly who are bedridden or have dementia

In Malaysia, about 20,000 patients have been diagnosed with dementia. When patients who have not been diagnosed by a doctor but are thought to be suffering from dementia are added, this number is expected to swell to about 60,000.[37] The number of patients with dementia, including Alzheimer's disease, is predicted to continue to rise, to about 40,000 by 2020, and about 140,000 by 2050.

While the number of dementia patients is expected to rise, the level of understanding of dementia is

[29] Tey Nai Peng (2012). "Socio-Economic Characteristics of Older Malaysians," *Profile of Older Malaysians Current and Future Challenges.* pp.35-37.
[30] Gill Raja (2012). "Circumventing the Marginalization of Older Citizens," *Profile of Older Malaysians Current and Future Challenges.* pp.228-230.
[31] Peng (2012). "Socio-Economic Characteristics of Older Malaysians". pp.37-38.
[32] Peng (2012). "Socio-Economic Characteristics of Older Malaysians". pp.37-38.
[33] On-site hearing survey on April 26, 2013 (University of the Third Age Malaysia).
[34] On-site hearing survey on March 18, 2013 (National Council of Senior Citizens Organisations Malaysia).
[35] On-site hearing survey on April 26, 2013 (University of the Third Age Malaysia)。
[36] On-site hearing survey on April 26, 2013 (University of the Third Age Malaysia)。
[37] Institute for International Socio-Economic Studies, Ltd. (2012) "Survey Research Report on the Advance of Aging and Smart Aging—Building Nice Places to Live That Transcend Generational Boundaries: 'Smart Aging Cities'", p.169.

low.[38] Although the World Health Organization (WHO) considers dementia to be one of the primary diseases, along with cancer and heart disease, in Malaysia there is a lack of awareness of dementia as a serious illness. Furthermore, support systems for caregivers are almost nonexistent. Care centers that provide care for dementia patients, such as the Alzheimer's Disease Foundation Malaysia (ADFM), only exist around Kuala Lumpur, and care in the home is the norm in provincial areas and farming villages.[39]

(2) State of utilization of care services

Table 1-11 shows the state of utilization of healthcare services and facilities by ethnic group. The proportion using only public healthcare services and facilities is highest in every ethnic group. Meanwhile, the proportion of ethnic Chinese using only private healthcare services and facilities is overwhelmingly higher than those of the other ethnic groups, a fact that perhaps reflects favorable economic conditions for ethnic Chinese.

However, differences among ethnic groups regarding the question of whether or not to use facilities in the first place can be seen. The proportion of ethnic Malays using facilities is lower than those of other ethnic groups due to their deep sense that the elderly are taken care of at home, and the fact that ordinary daycare centers do not provide halal meals.[40]

In addition, because in many cases the fees for elderly facilities are paid by the children of those who use them, sometimes children enter their parents in such facilities without the latter's consent.[41] It is said that 90% of the elderly who have been put into such facilities did not give their consent.

Table 1-11 State of Healthcare Services and Facilities Usage by Ethnic Group (2008) (%)

	Malay	Chinese	Indian	Other Bumiputra	Other
Use only public health care services and facilities	75	46	84	80	50
Use only private health care services and facilities	14	42	8	10	16
Use both public and private health care services and facilities	6	7	3	4	17
Use none/Other	5	5	5	6	17

Source: Hamid, Tengku Aizan (2012), *Meeting the Needs of Older Malaysians: Expansion, Diversification & Multi-sector Collaboration*, p.13.
http://familyrepository.lppkn.gov.my/270/1/Meeting_the_Needs_of_Older_Malaysians_(_Tengku_Aizan).pdf (accessed 15 October, 2013)

(3) State of caregivers for housebound seniors

Table 1-12 gives a breakdown of caregivers as of 2008. The children shoulder the heaviest responsibilities

[38] On-site hearing survey on March 19, 2013 (Alzheimer's Disease Foundation Malaysia)。
[39] On-site hearing survey on March 19, 2013 (Alzheimer's Disease Foundation Malaysia)。
[40] On-site hearing survey on March 18, 2013 (National Council of Senior Citizens Organisations Malaysia)
[41] On-site hearing survey on April 23, 2013 (Institute of Gerontology, UPM).

for care, at 47.5% of the whole, followed by spouses at 36.8%. Together, children and spouses account for over 80% of total care giving. Furthermore, children are assumed to be the care providers, a trend that is especially strong regarding women, ethnic Malays and Indians, and in rural areas.

In this way, the position held by children as care providers is significant, and this role is expected of them. However, as explained earlier, since a declining birthrate, an aging population, and the advance of women into society are moving ahead in Malaysia, it is expected that sooner or later it will become difficult for care to be shouldered by families alone. However, the Malaysian government does not wish to increase the number of public homes for the elderly beyond the current number and is pushing a shift toward care for the elderly in their households, or community care for the elderly.[42]

High-income earners with the means can hire a maid. However, the government's policies are insufficient for those who are not poor, but are middle class elderly who lack the economic resources to live in a home for the elderly or hire a maid.[43]

Though Malaysia needs 30,000 maids per year and foreign workers are expected to meet this need, the demand for maids is not met because the wage for maids in Malaysia is lower than in Hong Kong and Middle Eastern countries.[44] In order to encourage their employment in Malaysia, a memorandum of understanding on the increase of agent commission fee and improvement of labor condition was signed at the end of 2013 between the Malaysian Association of Foreign Workers Agencies (Papa) and the Indonesian Manpower Suppliers Association (Apjati). Indonesia is a major supplier of maids to Malaysia.

Table 1-12 Care Providers (2008) (%)

Spouse	Sibling	Parents	Children	Son-in-law/Daughter-in-law	Grandchild	Other relative	Neighborhood resident	Other
36.8	2.2	0.8	47.5	4.0	3.2	2.1	2.0	1.5

Source: Humid, Tengku Aizan (2012), *Meeting the Needs of Older Malaysians: Expansion, Diversification & Multi-sector Collaboration*, p.29.
http://familyrepository.lppkn.gov.my/270/1/Meeting_the_Needs_of_Older_Malaysians_(_Tengku_Aizan).pdf (accessed 15 October, 2013)

[42] In addition, the government has built virtually no new public facilities in the past 20 years. On-site hearing survey on April 18, 2013 (National Council of Welfare and Social Development Malaysia).

[43] On-site hearing survey on April 23, 2013 (Institute of Gerontology, UPM).

[44] "Najib, Susilo archive progress in talks on domestic maid issue," *New Straits Times*, 19 December, 2013, *New Straits Times (online)*.
http://www.nst.com.my/latest/najib-susilo-achieve-progress-in-talks-on-domestic-maid-issue-1.438636 (accessed 31 January, 2014)

Table 1-13 Those Expected to Be Care Providers (2005)

Care Provider	Gender		Ethnic Group			Region		Overall
	Male	Female	Malay	Chinese	Indian	Urban	Rural	
Spouse	30.3	9.3	19.4	25.9	9.8	21.2	20.1	20.7
Child	55.3	75.3	68.8	54.1	76.8	60.9	68.2	64.5
Grandchild	0.5	2.4	1.8	1.0	0.0	0.7	2.3	1.4
Sibling	1.2	1.2	1.0	1.8	1.2	1.4	1.0	1.2
Relative	0.8	2.8	1.1	1.3	2.4	2.2	1.1	1.7
Neighborhood resident/sibling	0.8	0.8	1.0	1.0	0.0	1.0	0.8	0.8
Other	3.0	2.8	2.9	2.8	3.7	2.9	2.9	2.9
None	8.0	5.4	3.9	11.9	6.1	9.7	3.6	6.8

Source: Humid, Tengku Aizan (2012), *Meeting the Needs of Older Malaysians: Expansion, Diversification & Multi-sector Collaboration*, p.25. http://familyrepository.lppkn.gov.my/270/1/Meeting_the_Needs_of_Older_Malaysians_(_Tengku_Aizan).pdf (accessed 15 October, 2013)

2. Current Government Initiatives Responding to Aging Issues

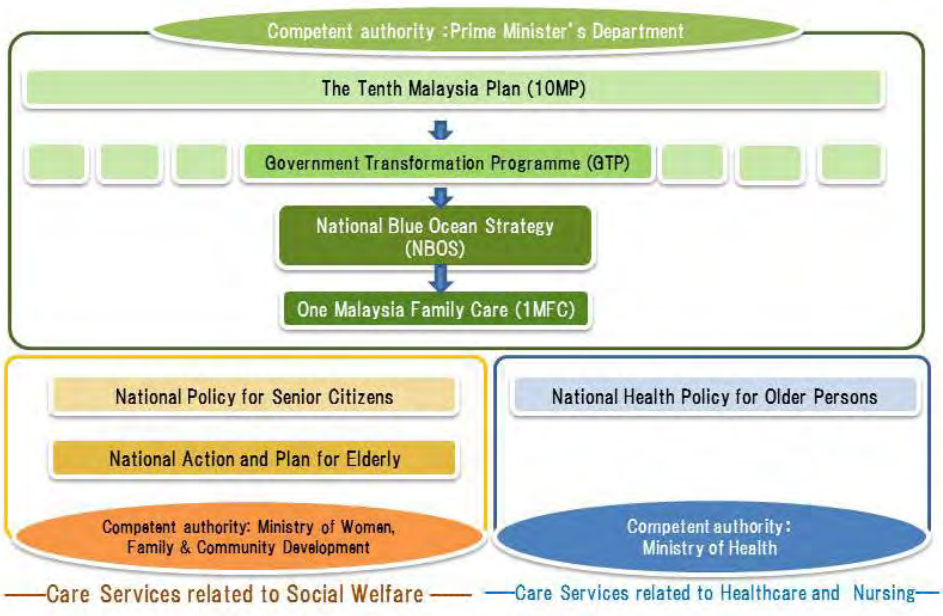
2.1. National Policy Framework for Aging Society

As set forth in its10th Malaysia Plan, the Government has recognized a special need for policy response to aging-related issues as one of the long-term priorities the country must address. While various social service programs targeting older persons are presented individually dealing with housing, income security, and health and medical care, these are generally designed to contribute to what is known as “active aging” of senior citizens, which assumes that they remain socially active and economically productive.

The Ministry of Women, Family & Community Development/Kementerian Pembangunan Wanita, Keluarga dan Masyarakat in Malay (KPWKM) and Ministry of Health (MOH), the major policy-making bodies on population aging, have set out specific strategies called the National Policy for Senior Citizens and the National Health Policy for Older Persons respectively. However, these key policies have not been incorporated into a set of concrete and coherent measures. Without an integrated institutional system, ministries provide their programs in a vertically-divided administrative structure. To rectify this, it is necessary to lay out a road map as a medium- and long-term strategy to develop and direct resources for aging-related care services. At the operational level, moreover, most of the existing service resources are available in limited areas. In many cases, facilities and services are not delivered to older persons on an equitable basis.

Addressing these issues under the framework of the Malaysia National Blue Ocean Strategy[45] (MNBOS or NBOS in Malay), the Government launched 1Malaysia Family Care (1MFC) on March 2013, which provides holistic support for target groups (including older persons, single mothers and people with disabilities) through delivering overall healthcare and welfare services. Accordingly, as a first step, the related ministries (mainly MOH) have started to prepare for consolidating the legal system. Aside from this development, Performance Management and Delivery Unit (PEMANDU) has led efforts by multiple government agencies, namely, MOH, KPWKM, and Economic Planning Unit (EPU) in Prime Minister’s Department to put an integrated legal framework regarding elderly care into place.

[45] The Malaysia National Blue Ocean Strategy is explained in detail at Chapter 2.1 (5).



Source: Compiled by Mitsubishi UFJ Research and Consulting, with reference to related documents

Figure2-1 Policy Framework for an Aging Population in Malaysia

(1) Tenth Malaysia Plan (10 MP)

The Malaysia Plan is a 5-year Malaysian government national development initiative. The Tenth Malaysia Plan (10MP) is the latest version of the national development plan (plan for 2010 to 2015). In fact, 10MP has been created in accordance with the Government Transformation Programme (GTP) and New Economic Model (NEM) as an action to translate these strategies and policies into action.[46]

Basically, 10MP is built on five key strategic thrusts which are[47];

1. Creating the environment for unleashing economic growth.

・ Several strategies have been developed to create an environment that fosters economic growth with the private sector as the main driver.

2. Moving towards inclusive socio-economic development.

・ Measures will be taken to ensure that income and wealth are distributed in an equitable manner.

3. Developing and retaining a First-World talent base.

・ Key to promote productivity and innovation-led growth. Strategies to develop, attract and retain quality talent base

4. Building an environment that enhances quality of life.

・ Economic growth will be supplemented by strategies to raise the quality of life of citizens, which is commensurate with the country's higher income status

[46]RSM Strategic Business Advisors Sdn. Bhd, (2010) "A Summary of The 10th Malaysia Plan". Retrieved from http://www.rsmi.com.my/WebLITE/Applications/productcatalog/uploaded/Docs/The%2010th%20Malaysia%20Plan%202.pdf.p.1

[47] RSM Strategic Business Advisors Sdn. Bhd (2010) "A Summary of The 10th Malaysia Plan". Retrieved from http://www.rsmi.com.my/WebLITE/Applications/productcatalog/uploaded/Docs/The%2010th%20Malaysia%20Plan%202.pdf.p.1

5. Transforming government to transform Malaysia.

- The role of government will evolve to become an effective facilitator in the transformation of the economy and provide quality services to citizens.

Specifically, the 10MP has been implemented with the objective to achieve a targeted gross domestic product (GDP) growth of 6% per annum over the next five years, which will be led by the private sector and underpinned by the services sector. Gross national income per capita is projected to rise to US$ 12,139 (about MYR 40,000) by 2015, from US$ 8,256 in 2010.[48]

The Tenth Malaysia Plan also highlighted several aspects involving the welfare of elderly and disabled persons. To build the nation's strength, National Policy for the Elderly and National Action Plan for the Elderly were revised to enable the elderly to realize their potential and utilize all possible opportunities. Therefore, a new national policy for senior citizens and its plan of action was renewed in 2011(regarding the National Policy and National Action Plan, please refer to 2.1. (2) and (3)).

Moreover, government will provide various facilities and privileges for the elderly such as special counters and seating areas in government agencies. Existing institutions for the elderly will be continuously upgraded to provide better care and services. According to Malaysian private audit & consulting company, RMS Strategic Business Advisor, up to year 2010, a total of 22 day care centers(Senior Citizen Activity Centre/Pusat Aktiviti Warga Emas: PAWE) have been established to take care of 16,300 older persons. In contrast, for people with disabilities 409 community-based rehabilitation centers have been set up to provide services such as disability screening and detection, vocational training, and dissemination of information on disabilities. In fact, employment opportunities for person with disabilities were enhanced through implementation of various policies in the public sector which a total of 7,975 PWDs was placed in the private sector through the electronic labor exchange system for PWDs.[49]

Within the objective of moving Malaysia towards inclusive socio-economic development, more initiatives have been developed to support older persons to lead productive and fulfilling societal roles by providing conducive environment for them to remain healthy, active and secure. Therefore, more programs will be undertaken to focus on enhancing elderly friendly infrastructure, improving access to affordable healthcare, ensuring adequate provision of shelters and improving financial security and opportunities for employment.[50] Government programs to create greater awareness among family members and the community in caring for older persons will also be promoted. In this regard, values such as familial responsibilities, understanding and caring for older persons will be given greater emphasis.

Government also will help in enhancing employment opportunities for the elderly, for example, the Ministry of Human Resources alleviated the burden on companies for paying Employee Provident Fund

[48]RSM Strategic Business Advisors Sdn. Bhd, (2010) "A Summary of The 10th Malaysia Plan". Retrieved from http://www.rsmi.com.my/WebLITE/Applications/productcatalog/uploaded/Docs/The%2010th%20Malaysia%20Plan%202.pdf.p.2.

[49] RSM Strategic Business Advisors Sdn. Bhd, (2010) "A Summary of The 10th Malaysia Plan". Retrieved from http://www.rsmi.com.my/WebLITE/Applications/productcatalog/uploaded/Docs/The%2010th%20Malaysia%20Plan%202.pdf.p.2.

[50] The Economic Planning Unit (2010). "10th Malaysia Plan"(http://www.pmo.gov.my/dokumenattached/RMK/RMK10_Eds.pdf) and several interviews with governmental institutions conducted in 2013.

(EPF) insurance premiums by half (13% to 6.5%) for their employees who are between 55-75 year-old. In addition, the database on employment opportunities for older persons under Jobs Malaysia[51] will be promoted more actively to create greater awareness for those who are actively looking for a job. Independent living also will be emphasized through the Home Help Service (HHS) [52]program by Social Welfare Department of Malaysia (JKM) where volunteers will provide assistance in managing the daily chores especially for those who live alone. Furthermore, day care centres for older persons (Senior Citizen Activity Centre/Pusat Aktiviti Warga Emas: PAWE), which are established in partnership with NGOs, will be expanded to ensure older persons are taken care of when family members are working.[53] At the same time, access to healthcare will also continue to be improved through provision of free transport to hospitals and clinics by JKM.

Tenth Malaysia Plan also emphasizes the integration of people not only the elderly but also people with disabilities, into society to enable them to be independent, productive and valued contributors. Universal design standards in building, public spaces and parks will be widely adopted to provide easy transportation access and create more disabled-friendly environment for them. Existing community-based rehabilitation centres will be upgraded and Community-based Rehabilitation Program will be improved in terms of multimedia technologies and information and communication technology (ICT).

Greater employment opportunities for PWDs will be promoted by targeting 1% disabled employment in the civil service. Other existing programs such as Job Coach will be broadened to ensure sufficient coverage to effectively assist PWDs in seeking, obtaining and retaining positions in open employment, through ICT programs such as an electronic labour exchange system for PWDs operated by the Labour Department. In addition, specialized learning institutions and vocational schools will be built and dedicated to PWDs.[54]

1) The Government Transformation Programme: GTP

The Government Transformation Programme (GTP) was unveiled on 28 January 2010 and is expected to contribute to making the country a developed and high-income nation as per the government's Vision 2020. To meet the remaining challenges to achieving Vision 2020, Government Transformation Programme (GTP) has been prepared as a roadmap in accordance with the principles of 1Malaysia, "People First, Performance Now". This roadmap details the objectives, outcomes and the initial set of actions – in areas identified as National Key Result Areas (NKRAs) and Ministerial Key Result Areas (MKRAs).[55]

The GTP has been structured to identify the areas in need of the most attention. Through extensive consultation with key stakeholders, from the Ministries to the citizens, the Government has come up with several pressure points that it has designated as National Key Results Areas (NKRAs). Moreover, the GTP also contains a Ministerial Key Results Area (MKRA) component, which addresses developmental goals not

[51] Job Malaysia website (http://www.jobsmalaysia.gov.my)
[52] HHS is explained in detail at 3.3. (2).
[53] From the interviews conducted in 2013.
[54] The Economic Planning Unit (2010). "10th Malaysia Plan". Retrieved from http://www.pmo.gov.my/dokumenattached/RMK/RMK10_Eds.pdf
[55] PEMANDU (2011). "GTP Overview". Retrieved from http://www.pemandu.gov.my/gtp/About_GTP-@-GTP_Overview.aspx

covered by the NKRAs.

Table2-1 National Key Results Areas (NKRAs)

No	NKRAs	Headed by
1	Reducing Crime	Minister of Home Affairs
2	Fighting Corruption	Minister in the Prime Minister's Department, in charge of Law
3	Improving Student Outcomes	Minister of Education
4	Raising Living Standards of Low-Income Households	Minister of Women, Family and Community Development
5	Improving Rural Development	Minister of Rural and Regional Development
6	Improving Urban Public Transport	Ministry of Transport
7	Addressing Cost of Living	Deputy Prime Minister

Source: PEMANDU website.[56]

In detail, The Government Transformation Programme (GTP) is a single blueprint that has been divided into three distinct horizons: GTP 1.0, the first horizons (2010-2012); GTP 2.0, enhancing changes (2013-2015); and GTP 3.0, further and beyond (2015-2020).[57]

(2) National Policy for the Elderly

In line with demographic change scenarios, the Government has taken the initiative to replace the National Policy for the Older Person in 1995 with the new National Policy for Senior Citizens, on January 5, 2011.[58] Revising the new elderly policy shows the government's commitment to preparing the country to face the challenges of ageing country in the future.

The National Policy for Senior Citizens identifies older persons as citizens who consist of different backgrounds and experiences, have the right to enjoy a comfortable life, are respected and may continue contributing to the development of the country. The policy aims to ensure their welfare in all dimensions, including health (healthy ageing), social life (active ageing), economy (productive ageing), spirituality (positive ageing) and environment (supportive ageing).

1) Policy Goals

Empower individuals, family and community by providing efficient and effective age-friendly services, as well as developing a supportive environment to enable and help older persons to live comfortably.

[56] PEMANDU (2012). "Overview". Retrieved from http://www.pemandu.gov.my/gtp/What_Are_NKRAs%5E-@-NKRAs_Overview.aspx

[57] PEMANDU, (2011). "The Story So Far". Retrieved from http://www.pemandu.gov.my/gtp/About_GTP-@-GTP-;_The_Story_So_Far.aspx

[58] 1Malaysia, (2012). "KAR1SMA Program for Elderly Speech by Prime Minister". Retrieved from http://www.1malaysia.com.my/speeches/program-kar1sma-warga-emas/

2) Policy Objectives

1. Develop a society committed to the ageing phenomenon and enable society to face old age
2. Facilitate access to lifelong learning among older persons, family and society
3. Ensure older persons live safely and are well protected
4. Establish a service delivery system that is effective and well-integrated to serve older persons
5. Increase the involvement of older persons in a community of all ages
6. Encourage the usage of research findings as a base in planning, monitoring and program assessments for older person.

3) Strategies

a) Promotion and Advocacy

- Focus on continuously promoting the issues of awareness and challenges of aging at all levels of society in order to increase the sensitivity to and public concern for aging as a cumulative process that occurs throughout life.
- Promote senior citizens as a national asset that can continue to contribute to national development by developing their capacity building through training and skills, as well as addressing the issues and challenges faced by them.

b) Lifelong Learning

- Focus on an investment in human capital that concentrates on early preparation and precautionary measures, as well as efforts in strengthening family-community relationships to improve the present and future well-being of older persons.
- All programs related to education, training and lifelong learning should stress the implementation of moral values, economic balance, health, social, physical environment and spirituality.
- Older persons should be given opportunity and space to contribute through learning and teaching programs, sharing of experiences and knowledge delivery, as well as skills so that their role in society can be maintained.

c) Security and Protection

- Ensure the safety of older persons and protect their access to basic necessities, social security and protection from neglect, mistreatment and abuse, through adequate legal provisions.[59]

[59] United Nation Human Rights website : Information and Good Practices for the Public Consultation on the Rights of Older Persons Pursuant to the Human Rights Council Resolution No.21/23 (http://www.ohchr.org/Documents/Issues/OlderPersons/PublicConsultation2013/MalaysiaHRCommission_SUHAKAM.doc)

d) Governance and Shared Responsibility

- This strategy prioritizes effective personal management, program execution, preparation of facilities and provision of services to realize the policy at various levels and agencies.
- Accountability in management and finance becomes the core of the delivery of services and facilities to increase the direct benefits to older persons.
- Strategies based on output and performance are carried out through the implementation of a standardized system where the Government acts as a monitoring agency, not a service provider.
- This strategy requires effective collaboration between all parties that have a role in developing programs and activities, as well as providing facilities and services. This cooperation involves the Government, private sector and non-government organizations.

e) Involvement and Unity between Generations

- Focus on efforts to nurture and strengthen complementary relationships through relationship reinforcement activities or programs, and unity among older persons and between various generations.
- The aspect of heritage and the relationship of mutual respect and helpfulness between generations should be highlighted in activities and programs.

f) Research and Development

- This strategy focuses on the collection and use of data on age and gender in all planning processes, in order to implement and assess programs which are age-friendly.
- This strategy is capable of increasing the involvement of stakeholders and the effectiveness in delivering the policy at various levels to develop comprehensive and continuous programs.[60]

(3) National Action and Plan for Elderly/Dasar Dan Pelan tindakan Warga Emas Negara

In February 2010, the Ministry of Women, Family and Community Development (KPWKM) announced a new policy for older persons called the National Action and Plan for Elderly/Dasar Dan Pelan tindakan Warga Emas Negara (DWEN). In 2011, the plan of action was approved for nationwide implementation.[61]

To achieve these national policies' objectives for older persons, the Government has sought to promote better understanding of welfare improvement and the circumstances of the elderly, from a wide range of people at the individual, household and community levels, utilizing educational and work opportunities.

[60]Ministry of Women Family and Community Development, (2011). "National Policy for Senior Citizens". pp.4-6.
[61] This plan is built on two preceding policies known as National Policy for Older Persons 1995 and Plan of Action for the Older Persons 1998.

Under the national policy for the elderly, all individuals, groups, volunteer organizations, communities, government agencies and the private sector shall undertake relevant programs and activities.

To achieve objectives of the national policy for the elderly, related groups/organizations need to make effort in an integrated and holistic manner.

(1) Educational agencies/facilities
Relevant learning and training programs shall serve senior citizens as opportunities to realize and develop their potential. Younger generation needs to foster better understanding of aging issues and their importance, through enhanced school curriculum and family education.

(2) Employment
Older persons are encouraged to continue to work, using their skills and experiences, which in turn will contribute to the overall development of the country. Economically independent, they will be able to obtain more satisfaction in their lives.

(3) Involvement in communities
Older persons are encouraged to participate in various family and community activities, taking their own roles.

(4) Recreation
To promote the recreational activities of older persons, residential area, parks and sports centers provide facilities suitable for their use.

(5) Transportation
The public transportation system should provide services that ensure trouble-free transit for older persons.

(6) Housing
Housing should be equipped with facilities that make older persons' daily life comfortable.

(7) Support for family caregiving
To assist older persons in living with their families, effective systems need to be established to help family caregivers who tend to remain in their residential area. Offering some kind of incentive is important to make family caregiving of the elderly dependent sustainable.

(8) Health
General or specialized hospitals, or healthcare centers should provide adequate medical examination services to older persons.

(9) Social security
A comprehensive social security system for older persons needs to be established.

(10) Media
Not only print media, but electric counterparts as well, shall play a significant role in increasing the awareness of aging issues.

(11) Research and development
Good aging policy design requires information gathering and research studies. KPWKM is a competent authority to coordinate and implement action plans.

Source: Complied based on KPWKM's official website
(http://www.jkm.gov.my/content.php?pagename=dasar_warga_emas_negara&lang=bm).

Figure2-2 Outline of National Action and Plan for Elderly (DWEN)

(4) National Health Policy for Older Persons

The National Health Policy for Older Persons is under the jurisdiction and responsibility of the Family Health Development Division, Ministry of Health. This policy is to emphasize the specific needs and circumstances of the health services for the senior citizens. In addition, this policy also focuses on the health economics of aging population due to the rising cost of medical services. Thus, the provision of optimal health care services, in terms of physical, mental and social wellbeing at all strata of society, is essential to

ensure healthy, active and productive ageing in the future.[62]

1) Policy Goal

To achieve optimal health for older persons through integrated and comprehensive health and health related services. The policy will be implemented through several stages over time, and through a continuing response to the changing health needs of older persons.

2) Policy Objectives

1. To improve the health status of older persons
2. To encourage participation in health promoting and disease prevention activities throughout the course of life
3. To provide age-friendly, affordable, equitable, accessible, culturally acceptable, gender-sensitive, seamless health care services in a holistic manner at all levels.
4. To advocate and support the development of an enabling environment for independent living (ageing in place)

3) Strategies

a) Health promotion

- Strengthening healthy lifestyle strategies throughout the course of life and integration of individual, family, community, and societal actions to enable older persons to adopt healthy, active and productive lives.

b) Provision of a continuum of comprehensive health care services

- The provision of comprehensive range of health care services, including preventive, promotive, curative, palliative and rehabilitative services through a seamless services delivery system.

c) Human resource planning and development

- The development of human resources must be in line with the rapid increase in the aged population and associated demands for training of health care providers at all levels.

d) Information system

- Strengthening and expanding information systems to assist in development, implementation, monitoring and evaluation of health programs and services for older persons.

[62] Family Health Development Division, (2008). “National Health Policy for Older Person”. p.11.

e) Research and development

- Encourage research in health and health-related issues of older persons for the purpose of creating standards in patient care and management, as well as planning, monitoring, and evaluation of program implementation and service provision.

f) Interagency and intersectoral collaboration

- Strengthening existing interagency network and developing new ties between all relevant agencies; government, non-government and private sectors in the provision of health care for older persons.

g) Legislation

- Advocate the development of new legislation and review existing laws, to ensure the preservation of the dignity and autonomy of older persons, maintain quality and standards of service provision, promote health, and prevent age discrimination and abuse of older persons.[63]

(5) Malaysia National Blue Ocean Strategy: MNBOS / NBOS[64]

In March 2013, the Prime Minister Najib Razak unveiled the Malaysia National Blue Ocean Strategy (MNBOS, or simply NBOS) as a part of the GTP set out in 10MP. By achieving two objectives of the key areas in four years within the period until 2016, NBOS is expected to become the cornerstone for realizing Vision 2020. One key area is higher income levels through achieving high economic growth and balanced economic development; another is enhanced public happiness through pursuing social security as well as social inclusion (redressing social gaps entrenched among different groups, such as the one between the elderly and young people)[65] .

In relation to aging issues, NBOS has laid the groundwork for a Home Help Service program within the GTP framework.

The progress of NBOS implementation is monitored by Malaysia Blue Ocean Strategy Institute (MBOSI), MOH and KPWKM. The NBOS framework has embraced NBOS7 underlying comprehensive healthcare and social security programs including 1 Malaysia Family Care.[66] To provide services for the elderly and single mothers, various actors such as the Government, the private sector and NGO are expected to work in

---

[63] Ministry of Women Family and Community Development, (2011). "National Policy for Senior Citizens".pp.13-15.

[64] Blue Ocean Strategy is difined by a business book written by W. Chan Kim and Renée Mauborgne, Professors of European Institute of Business Administration (INSEAD). While "Red Ocean" represents the existing market space as a metaphor for a cutthroat competition resulting in bloodshed, "Blue Ocean" is defined by untapped and uncontested market space. Hence the blue ocean strategy is a way of creating a new market. Other than Malaysia, Asian countries such as Singapore, Taiwan, Myanmar, Sri Lanka and Nepal have incorporated the Blue Ocean Strategy into their respective national (or local) development planning. Several countries in North and South America, and Middle East, as well as some local government agencies have also adopted the Blue Ocean Strategy concept in their public policy
(Blue Ocean Strategy website: http://www.blueoceanstrategy.com/national-blue-ocean-strategy/).

[65] Blue Ocean Strategy website http://www.blueoceanstrategy.com/malaysia-nbos/book/

[66] 1 Malaysia Family Care is explained in 2.1.(6).

cooperation.[67]

Developing an alliance with other programs such as 1 Malaysia Mobile Health Care, NBOS also seeks to promote volunteer activities of residents in delivering the services to socially vulnerable groups, including low-income elderly, schoolchildren, and single mothers.[68]

(6) 1 Malaysia Family Care (1MFC)

As mentioned in NBOS above, 1 Malaysia Family Care (1MFC) is a comprehensive healthcare and social security program targeting the elderly, single mothers, and people with disabilities. Voluntary workers help with implementation. Under NBOS, MOH and KPWKM jointly implement this social program, thereby minimalizing their operational costs.

According to one Malaysian newspaper[69], the country has 205 facilities for older persons, and of 7,000 elderly people surveyed, 4,000 people are covered by some kind of medical treatment. About 3,000 elderly people are bed-ridden at home. It is also estimated that there are about 3,000 people who have obtained some kind of training to provide special caregiving for the bed-ridden elderly.

Furthermore, it was reported that 1MFC had provided comprehensive healthcare services covering medical treatment, nutrition, dental health, immunization and rehabilitation of people with disabilities in 50 districts in the pilot projects related to 1MFC. By 2013, this program has delivered healthcare services to people with disabilities and single mothers.

2.2. Current Conditions and Challenges of the National Aging Policies

Section 2.1 outlined Malaysia's national policy framework and plans for its population aging. This section explores the extent to which these policies and programs are responding to ongoing aging issues.

National Policy for Senior Citizens has intended to enhance their welfare in all dimensions, which are health (healthy ageing), social life (active ageing), economic life (productive ageing), spiritual life (positive ageing) and environment (supportive ageing). One of the elderly support services devised to realize these objectives is PAWE, which will be discussed in Chapter 3, offering various programs nationwide including health promotion and lifelong learning. Development of PAWE will contribute to meet social, spiritual, and in part environmental needs of the elderly.

For medical and health issues, the National Health Policy for Older Persons has proposed a diverse set of healthcare support measures for the elderly. While seven strategic objectives are presented in this policy, major challenges for Malaysia are provision of sustainable and integrated healthcare services, human resource planning and development, research studies, and establishment of an information system to provide the foundation for design, implementation, monitoring and evaluation of the elderly healthcare programs and services.

[67] KPWKM's website (in Malay) http://www.kpwkm.gov.my/home
[68] JKM website (in Malay)
[69] Article from "BERNAMA March 8, 2013" by the Malaysian National News Agency

Other medical and health issues include inadequate facilities for the elderly, except for low-income groups, both in public and private sectors. This shortage has imposed constraints on expanding elderly assistance and long-term care services nationwide. Also, while the Department of Social Welfare under KPWKM has implemented Home Help Service (HHS)[70] as a national pilot project that brings community-based resources into home nursing care, the users are limited to as few as 1,600 people. It is essential for the Government to allocate more resources and develop the institutional framework for delivery of HHS throughout the country.

Development of techniques necessary for home care nursing provided by HHS also requires public support ("techniques" mentioned herein refer to care needs assessment, quantitative and qualitative level of caregiving services required, care management skills and nursing skills). A step-by-step approach will be needed to improve specific techniques to deliver HHS.

For the economic (income) issue addressed in the abovementioned national policy, the eligible elderly, who have no relatives to rely on and are without income, currently receive a monthly payment of 300 MRY. However, it is critical for them to obtain income from other sources in order to enhance the quality of their life. Except for retired public servants, Malaysia's pension system is in general not guarantteed. Thus, healthy senior citizens will need relevant public support to remain engaged in productive activities that ensure their income sources. The Economic Empowerment Program (EEP) currently carried out in PAWE has not been successful in increasing the income security of senior citizens. EEP's effects have been limited in terms of improvement of their physical ability, as well, as its activities are carried out mostly for recreational purposes (for instance, sale of garden vegetables). In order to promote productive aging (active aging, welfare), aging in place or successful aging envisioned in National Health Policy for Older Persons, a feasible reform proposal will be an essential step in improving EEP and expanding related services, particularly with regards to disease prevention and self-help of the elderly.

2.3. Public Administration on Aging Issues

(1) Administrative framework for key objectives: welfare and livelihood support, healthcare, income, living environment (housing security, infrastructure development, etc)

Principal ministries and agencies related to population aging in Malaysia are KPWKM, MOH, the National Advisory Council and Consultative Council for Older Persons (NACCO) in support of Prime Minister's Department, EPU and PEMANDU. The Ministry of Rural and Regional Development, the Ministry of Transport, and the Ministry of Agriculture and Agro-Based Industry are responsible for developing the living environment for older persons. The overall responsibilities of respective ministries and related laws are indicated below.

Basically, KPWKM has jurisdiction over the provision of social welfare services and programs to older persons through the relevant systems, planning and implementation, while delivery of health-related assistance comes under MOH. NACCO is subject to the jurisdiction of KPWKM, with its Minister serving as

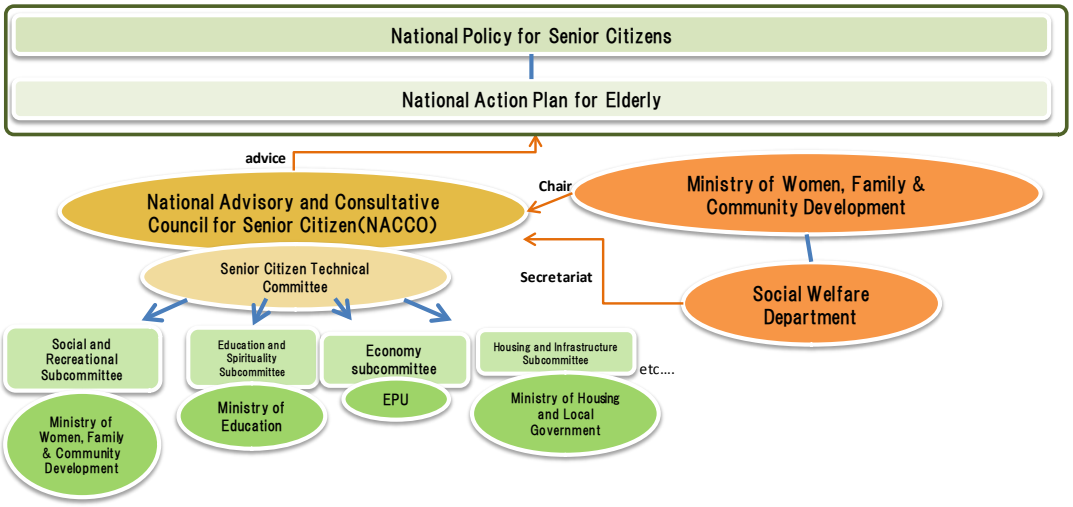
[70] HHS is explained in 3. 3. (2).

chairperson. The members of the Council include related ministries, representatives of private sector groups and non-profit organizations, and experts of aging issues. Under NACCO, several technical subcommittees are organized, representing each ministries concerned (see Table 2-3).

Table2-2 Agencies related to Population Aging and their Responsibilities

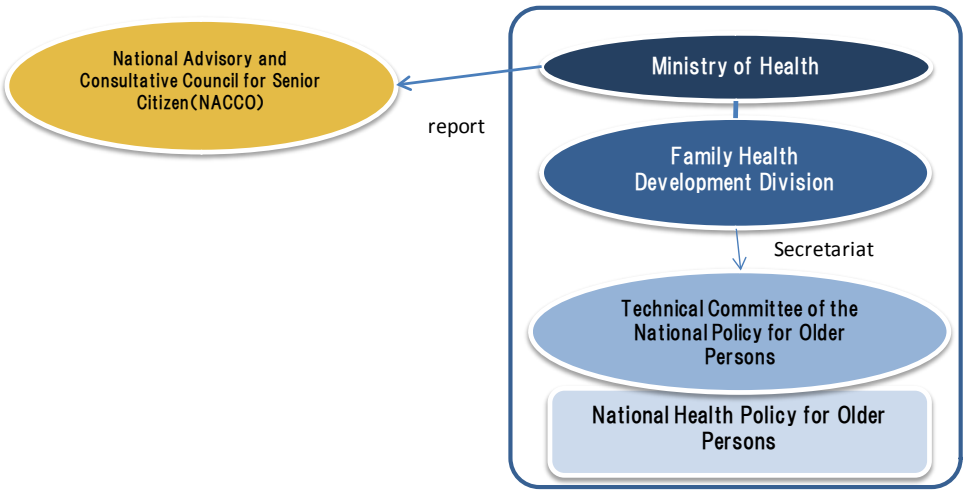
	Caregiving and preventive care	Healthcare	Income/Employment	Living Environment (Housing, Infrastructure development)
Agencies in charge	KPWKM	MOH	EPF Department of Public Service	Ministry of Rural and Regional Development Ministry of the Federal Territories and Urban Wellbeing Ministry of Agriculture and Agro-Based Industry Ministry of Housing and Local Government
Major services and programs	・Facility services to protect the elderly in poverty and those in social isolation ・Home caregiving service ・Promotion of social and community participation and self-fulfillment	・Formal healthcare system ・Medical benefits covered by the government pension system	・Retirement savings fund ・Pension scheme for public sector employees	・Housing policy for older persons ・Barrier-free and universal design
Major laws	Care Center Act	Private Medical Facility and Service Act	Retirement Fund Act Pension Act	Housing Act

Source: Compiled by Mitsubishi UFJ Research and Consulting, with reference to related documents



Source: Compiled by Mitsubishi UFJ Research and Consulting with reference to related documents

Figure 2-2 Organizational Chart of Administration on Aging in Malaysia (Social Welfare Services)



Source: Compiled by Mitsubishi UFJ Research and Consulting with reference to related documents

Figure 2-3 Organizational Chart of Administration on Aging in Malaysia (Health and Nursing Care Services)

The administrative policy framework on aging, in terms of health and nursing care, has not been clearly elaborated in Malaysia, compared to its social welfare framework. The Ministry of Health takes initiatives mainly for in-facility elderly care under the Care Centre Act 1993 for the Elderly Care Facilities and the Private Healthcare Facilities and Services Act 1998 for Nursing Home.

A National Committee for Health and Nursing care, which is equivalent to NACCO in social welfare services does not exist, but there is a Technical Committee under the National Policy for Older Persons under the Ministry of Health. Under this committee, National Health Policy for Older Persons was formulated. The Ministry of Health regularly reports on the health related issues of the National Policy for Senior Citizens.

Currently the Ministry of Health has been discussing a new approach to providing comprehensive in-facility care service for the elderly, including the elderly who need long-term care (refer to Chapter 3 for detail).

2.4. Ministries and Agencies related to Population Aging

(1) Ministry of Women, Family and Community Development (MWFCD) /Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM)

a) Mission

The Fourth World Conference on Women held in Beijing in 1995 marked an important milestone for Malaysia in the protection and promotion of human rights and the status of women. This resulted in the establishment of the Ministry of Women Affairs in January 2001. Now, as the Ministry of Women, Family and Community Development, this agency is responsible for planning and formulating social welfare policies for social groups such as people with low income, older persons, schoolchildren and women.

In accordance with the expansion of its responsibilities and functions, the Ministry of Women Affairs was

renamed Ministry of Women and Family Development (KPWK) in February 2001. Subsequently, the Department of Women Affairs (HAWA) and the National Population and Family Development Board (LPPKN) came under the control of KPWK.[71]

After the general election in 2004, KPWK's functions were further expanded, and it was renamed again Ministry of Women, Family and Community Development (KPWKM in Malay), as it is known today. Four subordinate agencies include Department for Women Development (JPW), Social Welfare Department of Malaysia (JKM), National Population and Family Development Board (LPPKN), and Social Institute of Malaysia (ISM).

As a part of the effort to achieve "Wawasan 2020 (Vision 2020),"[72] KPWKM strives to extend social the welfare services that contribute to creating a caring and prosperous society. KPWKM's vision, mission and strategies are summarized as follows.

i. Vision

Work in the forefront to achieve gender equality, family and community development as a caring and prosperous basis of a fairly developed country.

ii. Mission

Integrate the perspectives of women and society into the mainstream of national development, and strengthen families and communities towards improving social welfare.

iii. Goal

Develop a prosperous society through the sharing of responsibility for strategic development and delivery of social services in an efficient and effective manner.

iv. Objectives

1. Increase the participation and active role of women, families and communities as contributors and beneficiaries of development countries.
2. Recognize the importance of preserving the rights of women, families and communities fairly and impartially without discrimination.
3. Extend equal opportunities to women and society in social, economic and political life.
4. Strengthen the family institution.

[71] HAWA was restructured and renamed JPW, as it went through several organizational changes.
[72] Proposed by the former Prime Minister Mahathir in 1991, a set of objectives envisions Malaysia's future as a fully developed country.

5. Ensure the delivery and support systems efficiently and effectively.[73]

v. Strategies

1. Ensure a gender perspective, family and community groups are integrated in policy formulation and planning and program implementation.
2. Strengthen the implementation of family values in society by working closely with government agencies, private and non-governmental organizations.
3. Audit existing rules and propose new legislation to ensure the life, protection and advancement of women, families and communities.
4. Conduct research and development programs in the areas of gender, population, family and community development to promote innovative approaches in planning and program development.
5. Develop and strengthen the social database for comprehensive and integrated planning, monitoring and evaluation of programs for the target group.
6. Enhance skills and knowledge, and empower target groups to enable effective participation in national development.
7. Increase and diversify opportunities for targeted groups to improve the socio-economic development programs through cooperation between implementing agencies.
8. Strengthen the network of national and international levels in order to share information, experiences and expertise.
9. Establish monitoring and evaluation mechanisms to improve policy and program implementation.
10. Expand access to information and communication technology (ICT) on women, families and communities.
11. Consolidate and strengthen service delivery at all levels through the financial and human resource management and optimum technology progression.
12. Disseminate information on facilities and services available in the various agencies and organizations to help women, families and communities obtain the services required[74]

The details of the budget received for the Ministry of Women, Family and Community Development are shown in the next table:

[73] Ministry of Women Family and Community Development, (2012).“Vision, Mission and Objective”. Retrieved from http://www.kpwkm.gov.my/visi-misi-dan-objektif

[74] Ministry of Women Family and Community Development, (2011).“Ministry Strategies”. Retrieved from http://www.kpwkm.gov.my/strategi.

Table 2-3 Budget for Operating Expenditure and Development Expenditure of Ministry of Women, Family and Community Development

Year	Operating Expenditure (MYR Million)	Development Expenditure (MYR Million)
2009	827	218
2010	1,903	499
2011	1,806	181
2012	1,808	158
2013	1,802	49

Data for 2009-2011 are real expenditures, while data for 2012-2013 is estimated expenditure.
Source: Ministry of Finance Budget Statement.[75]

Specifically, the Ministry of Women, Family and Community Development is responsible for ensuring the social welfare of Malaysian community as a whole, including women, senior citizens, children, destitute persons, families, and persons with disabilities. In order to be more progressive and efficient, the Social Welfare Department of Malaysia has been formed to provide direct social service assistance to these targeted groups.

2) Social Welfare Department (Social Welfare Department of Malaysia: JKM)

JKM was established in 1946 as a public service agency providing welfare services to individual and community development, families, groups and communities. Services were provided to address social problems in order to create a harmonious society. Since the establishment, JKM underwent several structural reforms intended to improve social welfare services. In 2004, JKM was put under the purview of the Ministry of Women, Family and Community Development, Malaysia.[76] JKM has branches in 15 states, including Federal Territories, 104 districts and 63 institutions with a total of more than 6,300 employees.[77]

The vision, mission and strategies of JKM are summarized as follows.

i. Vision

A Prosperous and Caring Society

ii. Mission

To develop society towards social well-being

iii. Objectives

[75] Ministry of Finance, (2013). "Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.pp.1
[76] Social Welfare Department, (2011). "Social Welfare Department History". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=5&Itemid=89&lang=en
[77] Social Welfare Department, (2011). "Transformation Plan for Social Welfare Department 2011-2015" Retrieved from http://www.jkm.gov.my/images/stories/pdf/pelan_transformasi_jabatan.pdf.p.51.

1. To provide shelter and rehabilitation for the Department's target groups.
2. To develop the community through a process of changing attitudes and increasing capability for self-reliance.
3. To create a society with a caring culture.
4. To improve the well-being of society through professional social welfare and social development services and strategic sharing of responsibilities.[78]

iv. Strategies

1. Optimize the individual's ability, potential and the well-being of the Department's target groups.
2. Ensure the integration of social welfare aspects in the planning towards achieving overall socioeconomic development.
3. Increase the role and capability of the Department as the main axis in the planning and evaluation of Social Welfare Development programmes at national and international levels.
4. Increase in smart and strategic partnership through cooperation with all groups of society, non-governmental bodies and international agencies.
5. Strengthen and improve the delivery of social services at all levels.
6. Improve the management and optimize the utilization of human resources.
7. Improve the quality of financial planning and management and Information and Communication Technology.[79]

v. Target Groups

The Social Welfare Department has at least 7 target groups all together including:

1. Children (Child Act 2001).

· Children under the age of 18 years old

2. People with Disabilities
3. Senior Citizens

· A person who is aged 60 years and above

4. Destitute Persons (Destitute Person Act 1977).
5. Families

· Single parents, victims of domestic violence, the poor and people with problems

6. Victims of Natural Disaster
7. Voluntary Welfare Organizations (Societies Act 1966)

vi. Core Business[80]

[78] Social Welfare Department, (2011). "Vision, Mission and Objectives". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=23&Itemid=90&lang=en
[79] Social Welfare Department, (2008)."Strategy". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=44&Itemid=91&lang=en
[80] Social Welfare Department (2011). "Transformation Plan for Social Welfare Department 2011-2015"http://www.jkm.gov.my/images/stories/pdf/pelan_transformasi_jabatan.pdf. pp.28-29

1. Prevention
2. Protection
3. Rehabilitation
4. Development
5. Integration

a) Budget (expenditure) amounts and changes in allocation

Figures for budget allocation for KPWKM and the respective subordinate agencies are not available, but the amounts of expenditures are provided as follows.

Table 2-4 Budget for Operating Expenditure and Development Expenditure of Ministry of Women, Family and Community Development

Year	Operating Expenditure (MYR Million)	Development Expenditure (MYR Million)
2009	827	218
2010	1,903	499
2011	1,806	181
2012	1,808	158
2013	1,802	49

Data for 2009-2011 are real expenditures, while data for 2012-2013 is estimated expenditure.
Source: Ministry of Finance Budget Statement.[81]

Table 2-5 Budget for Programs under the Social Welfare Department

No	Items	2010 (MYR)	2011 (MYR)	2012 (MYR)	2013 (MYR)
Specific Program					
1	Senior Citizens Institution	-	539,600	539,600	380,000
2	PWDs Community Rehabilitation Program	-	56,563,800	79,463,800	75,983,800
3	PWDs Institution	-	402,000	402,000	402,000
4	PWDs Socioeconomic	-	108,144,000	359,739,000	315,263,800
5	Senior Citizens Socioeconomic	-	166,636,000	496,011,000	489,000,000
One-off Program					
5	NKRA: Home Help Service for Elderly	-	-	-	5,772,000

Source:
Federal Government Budget 2013.[82]
Federal Government Budget 2012.[83]
Federal Government Budget 2011.[84]

[81] Ministry of Finance, (2013). "Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.pp.1
[82] Ministry of Finance, (2013). "Federal Government Budget 2013, Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.
[83] Ministry of Finance, (2012). "Federal Government Budget 2012". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf

Table 2-6 Budget for Protection Services

No	Program	2010 Expenditure (MYR)	2011 Expenditure (MYR)*	2012 Expenditure (MYR)	2013 Expenditure (MYR)
1	*Seri Kenangan* Home (Elderly)	-	6,638	6,630,720	13,350,000
2	Community Rehabilitation Program (PWDs)	6,950,000	8,400,000	1,362,000	981,300
3	PWDs Local Service Center	1,400,300	1,890,399	1,691,950	200,000

Source:
Federal Government Budget 2013.[85]
Federal Government Budget 2011.[86]
Note: *Real budget for year 2011

Table 2-7 Budget for the Senior Citizens and Family Division, 2010-2013

	2010	2011	2012	2013
Budget (MYR)	197,291,200	33,137,500	36,539,400	41,804,800

Source:
Federal Government Budget 2013.[87]
Federal Government Budget 2012.[88]
Federal Government Budget 2011.[89]

Table 2-8 Budget for the PWDs Development Department, 2010-2013

	2010	2011	2012	2013
Budget (MYR)	185,631,800	23,199,300	23,781,200	27,074,900

Source:
Federal Government Budget 2013.[90]
Federal Government Budget 2012.[91]
Federal Government Budget 2011.[92]

b) Organizational and personnel structure

In the year 2012, the total staff working under this Ministry is approximately 7,456 people.

---

[84] Ministry of Finance, (2011). "Federal Government Budget 2011".Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf.
[85] Ministry of Finance, (2013). "Federal Government Budget 2013, Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.
[86] Ministry of Finance, (2011). "Federal Government Budget 2011".Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf.
[87] Ministry of Finance, (2013). "Federal Government Budget 2013, Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.
[88] Ministry of Finance, (2012). "Federal Government Budget 2012". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf
[89] Ministry of Finance, (2011). "Federal Government Budget 2011".Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf.
[90] Ministry of Finance, (2013). "Federal Government Budget 2013, Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.
[91] Ministry of Finance, (2012). "Federal Government Budget 2012". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf
[92] Ministry of Finance, (2011). "Federal Government Budget 2011".Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf.

The Social Welfare Department operation is divided into two levels; national and state . Under the national level, there are two deputy directors general which are the deputy director for planning and the deputy director for operations. Furthermore, there are 6 departments under the purview of the deputy director for operation which are: Senior Citizens and Family Division, Children Division, Community Development Division, Socioeconomic Development and Financial Assistance Division, Community Service Order Division, and PWDs Development Department. Thus, all issues and activities related to the elderly are managed by the Senior Citizens and Family Division. Meanwhile, persons with disabilities are under the jurisdiction of the PWDs Development Department.[93]

The objective of the Senior Citizens and Family Division is to improve the well-being of the elderly, the poor and problematic families through care services, protection and rehabilitation as well as development programs, in an efficient and effective way.

In addition, the PWDs Development Department is established with the purpose of providing services and facilities protection, rehabilitation and development to improve the well-being and integration of persons with disabilities into society.

The details of the budget and staff for the Department of Senior Citizens and Family Division and PWDs Development Department are as follows;

Table 2-9 Number of Staff in the Senior Citizens and Family Division, 2010-2013

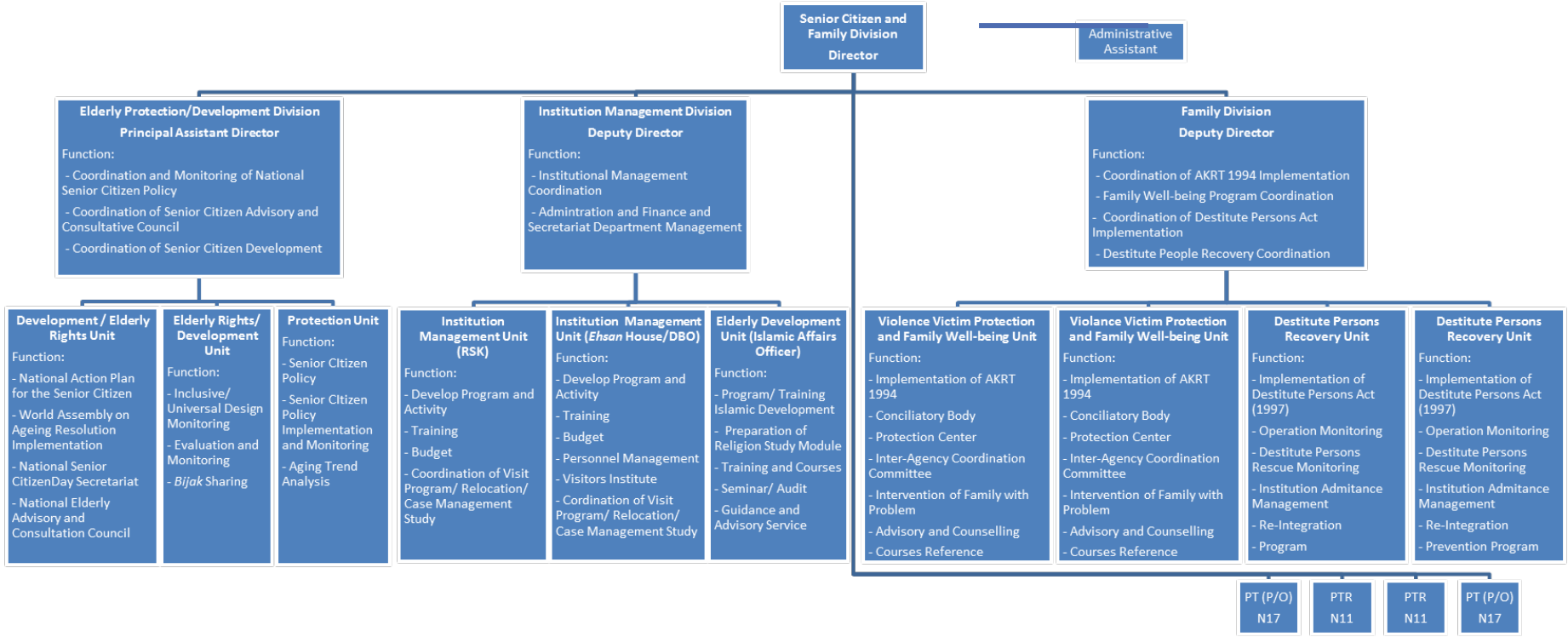
	2010	2011	2012	2013
Staffs	937	941	937	937

Table 2-10 Number of Staff in the PWDs Development Department, 2010-2013

	2010	2011	2012	2013
Staffs	656	654	651	651

Source:
Federal Government Budget 2013.[94]
Federal Government Budget 2012.[95]
Federal Government Budget 2011.[96]

[93] Social Welfare Department, (2012). "Organizational Chart". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=22&Itemid=93&lang=en
[94] Ministry of Finance, (2013). "Federal Government Budget 2013, Ministry of Women Family and Community Development". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b48.pdf.
[95] Ministry of Finance, (2012). "Federal Government Budget 2012". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf
[96] Ministry of Finance, (2011). "Federal Government Budget 2011".Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf.



Soucre: Department of Social Welfare [97]

Figure 2-4 Senior Citizens and Family Division Functional Chart

[97] Department of Social Welfare, (2013). "Senior Citizen and Family Division Functional Chart". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=104%3Abahagian-warga-tua-dan-keluarga-wtk&catid=30%3Acarta-fungsi&Itemid=94&lang=en

(2) National Advisory and Consultative Council for Older Persons: NACCO

NACCO is responsible for the implementation of the National Policy for Senior Citizens and National Action and Plan for Elderly (DWEN).

The Council consists of related Ministries, representatives of the private sector and non-profit organizations, and experts on aging issues. The Minister of Women, Family and Community Development serves as the chairperson of NACCO. Based on a report submitted by technical subcommittees, NACCO lays out the delivery of commitments set out in aging-related national policies. The Social Welfare Department acts as the secretariat of NACCO.

1) Technical Committee of the National Policy for Older Persons

The Technical Committee of the National Policy for Older Persons helps implement aging-related policy and action plans under NACCO. The Senior Vice Minister of Women, Family and Community Development serves as the chairperson of the Technical Committee. The members include representatives of various agencies that are directly involved in developing programs for older persons. The Technical Committee has been set up to design, implement, monitor, and evaluate such programs in accordance with National Policy for Senior Citizens and DWEN.

The Policy Department of KPWKM works for the secretariat of the Technical Committee. In line with state-level planning, the Committee implements annual development programs and activities for older persons, followed by reporting feedback to NACCO.

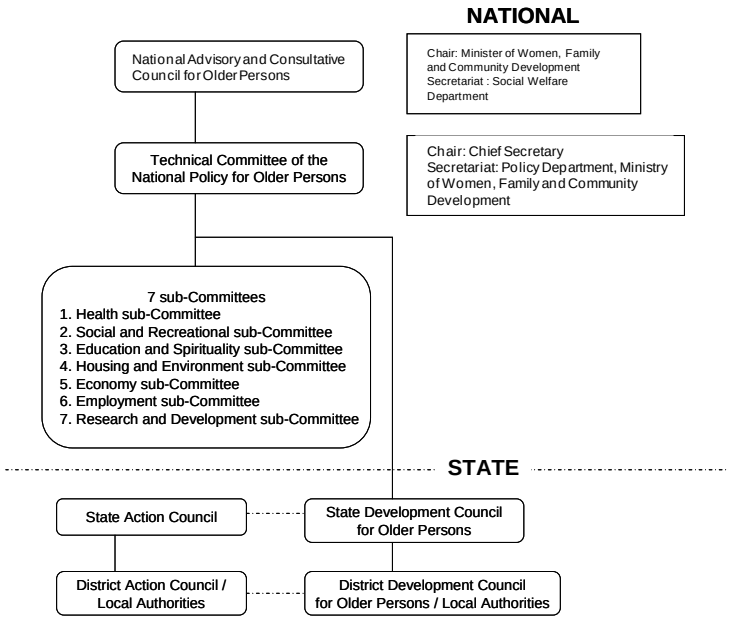
The Technical Committee is made up of seven subcommittees. Respective subcommittees are required to report on their activities to the Technical Committee. Chairs of the subcommittees are shown as below.

Table 2-11 List of Subcommittees

Subcommittee	Chair
Health	Ministry of Health
Social and Recreational	Department of Social Welfare
Education and Spirituality	Ministry of Education
Housing and Environment	Ministry of Housing and Local Government
Economy	Economic Planning Unit, Prime Minister's Department: EPU
Employment	Ministry of Human Resource
Research and Development	Ministry of Science, Technology and Innovation

Note: Each subcommittee consists of related ministries and representatives of the private sector and NGOs.

Source: National Policy for Senior Citizens [98]



Source: National Policy for Senior Citizens [99]

Figure 2-5 Organizational Structure for Implementation of National Policy for Senior Citizens and DWEN

[98] Ministry of Women, Family and Community Development (2011)."National Policy for Senior Citizens". pp.12-17

[99] Ministry of Women, Family and Community Development (2011)."National Policy for Senior Citizens". pp.12-17

(3) Ministry of Health: MOH / Kementerian Kesihantan Malaysia:KKM

a) Role

The main focus of the Malaysian health sector is to achieve 'quality of life of an advanced nation'. In fact, quality healthcare and active healthy lifestyles has been set as the main Key Result Area (KRA) for the health sector for the 10MP. The outcome is to ensure the provision of and increase accessibility to quality health care and public recreational and sports facilities to support active healthy lifestyles. MOH's strategies are summarized as follows.

i. Strategies

1. Establish a comprehensive healthcare system and recreational infrastructure
2. Encourage health awareness and healthy lifestyle activities
3. Empower the community to plan or implement individual wellness programme (responsible for own health)
4. Transform the health sector to increase the efficiency and effectiveness of the delivery system to ensure universal access

ii. KRAs

1. Health sector transformation towards a more efficient and effective health system that ensuring universal access to healthcare
2. Health awareness and healthy lifestyle
3. Empowerment of individuals and communities to be responsible for their own health

The Ministry of Health (MoH) has been entrusted by the Economic Planning Unit (EPU) with identifying Technical Working Groups (TWGs) under the Thrust 4 Mission Cluster Group (MCG) - Quality Healthcare and Active Healthy Lifestyle - involving inter-agency and multi-sectoral membership. The Ministry has identified five TWGs:

1. Health Sector Transformation (Service Delivery)
2. Health Sector Transformation (Finance and Governance)
3. Health Sector Transformation (K-economy – Human capital, Information Technology, Research and Development / Innovation)
4. Health Awareness and Healthy Lifestyle
5. Empowerment of individuals and community to be responsible for their own health

The outcomes, strategies and KPIs identified by the TWGs will be utilized to prioritize programmes, projects and activities in line with the National Programme finalized earlier by MOH and EPU in the National Health Sector Development Program.

Hence, MOH also has identified five health sector functional programmes that serve as the mode to allocate funding for the 10th Malaysia Plan: [100]

1. Population Health Programme
2. Personal Health Programme
3. Research and Innovation
4. Human Capital Development Programme
5. Technical and Other Support Programme

In 2008, the Ministry of Health has come out with the National Health Plan: 10th Malaysia Plan 2011-2015. The plan to work together towards improving the Malaysian health care system is based on concept of 1 Care for 1 Malaysia. 1 Care is a restructured national health system that is responsive and provides choice of quality health care, ensuring universal coverage for health care needs of the population, based on solidarity and equity. The aim of the 1 Care for 1 Malaysia concept is to create an effective, efficient, fair and high-tech system of health care, as well as being responsive and further improving access to various levels of appropriate health care to all Malaysians. [101]

The vision, mission and strategies of MOH are summarized as follows.

i. Vision

A nation working together for better health.

ii. Mission

The mission of the Ministry of Health is to lead and work in partnership to facilitate and support the people:

1. To attain fully their potential in health
2. To appreciate health as a valuable asset
3. To take individual responsibility and proactive action for their health
4. To ensure a high quality health system that is:

- customer-centered
- equitable
- affordable
- efficient

[100] Ministry of Health, (2010). "Country Health Plan, 10th Malaysia Plan 2011-2015". Retrieved from http://www.moh.gov.my/images/gallery/Report/Country_health.pdf. pp.10-11

[101] Ministry of Health, (2010). "Country Health Plan, 10th Malaysia Plan 2011-2015". Retrieved from http://www.moh.gov.my/images/gallery/Report/Country_health.pdf. pp.8

- technologically appropriate
- environmentally adaptable
- innovative

5. with emphasis on:

- professionalism, caring and teamwork values
- respect for human dignity
- community participation

iii. Objectives [102]

1. To assist an individual in achieving and sustaining as well as maintaining a certain level of health status to further facilitate them in leading a productive lifestyle - economically and socially.
2. This could be materialized by introducing or providing promotional and preventive approaches, in addition to an efficient treatment and rehabilitation services, which is suitable and effective, whilst keeping priority focus on the less fortunate groups.

2) Family Health Development Division

The Family Health Development Division under the Ministry of Health [103] is the core of the public health service for the country. Services provided are comprehensive, covering all ages from birth to the end-of-life, through a variety of public health facilities. The scope of services consists of five components, namely "health, illness, emergency, clinical support and health informatics". This department is the secretariat for the Technical Committee of the National Policy for Older Persons.

All of these types of services have been delivered through a variety of health facilities, such as health facilities, of which there are more than 3,000 clinics. In addition, services are also delivered through more than 200 mobile service units by land, air and water to residents in remote areas. In fact the visitors of these facilities have reached 40 million people annually.

The Family Health Development Division is responsible for carrying out and developing strategies, from a variety of approved policies. The Family Health Development Division monitors the progress of project activities at the grassroots level of the individual and the family. Therefore, to accomplish this responsibility it has been divided into two sub-sectors which are: Family Health Sector and Primary Health Care Sector. In other words, one could

[102] Ministry of Health (2011). "Country Health Plan 10th Malaysia Plan 2011-2015". Retrieved from http://www.moh.gov.my/images/gallery/Report/Country_health.pdf.p.8

[103] Family Health Development Division (2012)."Family Health Development Division". Retrieved from http://fh.moh.gov.my/v3/index.php/en/bahagian-pembangunan-kesihatan-keluarga

consider that the Family Health Sector provides the software functions, while the Primary Health Sector acts as the hardware.

The Family Health sector consists of 6 branches which are responsible for planning and implementation of programs in accordance with "the life cycle of ages". The branches are;

1. Mother's Health
2. Perinatal, Neonatal and Child Health
3. Adolescent Health
4. Women and Men’s Health
5. Elderly Health
6. Rehabilitation Services and Special Needs

In contrast, the Primary Health Care sector is responsible for carrying out plans to facilitate the implementation of the program among the population and integrate services with the other agencies, as listed below. [104];

1. Policy and Primary Health Care Services
2. Primary Health Care Medical Care
3. Clinical Support Primary Health Care
4. Primary Health Care Informatics

Elderly health unit under the family health sector has identified its objective to achieve optimal health for the elderly through health and related services in a comprehensive and integrated manner. This Elderly health unit has adopted the National Health Policy for Older Persons and Plan of Action of Health Services for Older Person.

The services provided for the elderly in health clinics around the country include:

1. Health promotion and education.
2. Screening and health assessment.
3. Medical examination, counseling, treatment and referral.
4. Home visit and treatment.
5. Rehabilitation treatment (Physical and occupational rehabilitation).
6. Social, welfare and recreational activities.

The Elderly Health Unit under the Family Health Development Division is the provider of senior citizens health services in Malaysia. This division has been assisted by the Health

[104] Family Health Development Division, (2012).“Family Health Development Division”. Retrieved from http://fh.moh.gov.my/v3/index.php/en/bahagian-pembangunan-kesihatan-keluarga

Education Division in the promotion of activities. The Health Education Division will issue brochures, pamphlets or materials related to elderly health care and organize activities for senior citizens like daily exercise promotion, promotion of healthy diet as well as provide training for staff as preparation for service provision for elderly.

a) Budget amount

The overall budget (expenditure) of MOH is indicated as below.

Table2-12 Budget for Operating Expenditure and Development Expenditure for Ministry of Health

Year	Operating Expenditure (MYR Million)	Development Expenditure (MYR Million)
2009	12,173	2,540
2010	12,697	3,569
2011	14,899	1,958
2012	14,998	1,873
2013	17,353	1,924

Note: Data for 2009-2011 are real expenditures, while data for 2012-2013 is estimated expenditure.
Source: Ministry of Finance [105]

Table2-13 Budget for Family Health Development Division

	2010	2011	2012	2013
Budget (MYR)	1,461,807,100	1,611,221,300	1,644,919,100	1,953,579,000
Staffs	41,118	40,826	41,905	41,905

Source:
Federal Government Budget 2013 [106]
Federal Government Budget 2012 [107]
Federal Government Budget 2011 [108]

(4) Prime Minister's Department: PMD

The Prime Minister's Department, established in 1958, was Formerly known as General

[105] Ministry of Finance, (2013)."Federal Government Budget 2013, Ministry of Health". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b42.pdf
[106] Ministry of Finance, (2013)."Federal Government Budget 2013, Ministry of Health". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b42.pdf
[107] Ministry of Finance, (2012)."Federal Government Budget 2012". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf
[108] Ministry of Finance, (2011)."Federal Government Budget 2011". Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf

Administration. The department was reorganized into nine divisions, Innovation and Human Resource Management (BIPSM), Finance (B. Kew), Development, the Accounts (BA), Management Services (BKP), Internal Audit, Corporate Communications Unit (UKK), and Events Management and Legal Adviser Office. All nine divisions report to the Senior Deputy Secretary-General and are assisted by the two Deputy Secretaries-General, who are Deputy Secretary-General (P) and Deputy Secretary-General (K&P).

Its main roles and functions are follows [109];

1. Providing support services including administration, finance, human resource management, security, social and other services to staff of PMD.
2. Management of staff quarters, office spaces, and rest and recreational facilities to provide conducive and comfortable environment for the civil servants.
3. Efficient and effective management of all property owned by the Federal Government.
4. Improvement of the quality of the Malaysian Civil Service to be more efficient, effective, and responsive, with integrity, and cultivating and promoting the usage of information technology in the public service.
5. Providing efficient, high-quality and effective services to the Cabinet and the Chief Secretary, who also acts as Secretary to the Cabinet, as well as tracking and monitoring the implementation of Government decisions.
6. Serve as a reference centre for all issues pertaining to security and protection encompassing physical security, documents and personnel formulation, issuing and establishing security policy and its proper implementation.
7. Managing State Protocol and Ceremonies, Conferment of Federal Awards, Official Visits by Foreign Heads of State and Dignitaries, International Conferences and Putrajaya International Convention Centre, with the highest standard of excellence.
8. Establishing the coordination of the National Economic Development policies, strategies and programs for the medium- and long-terms.
9. Serve as the central agency that monitors implementation of policies, strategies, programs and development projects, as well as resolves related issues efficiently and effectively, to ensure they are implemented in line with the national development goals.
10. Enforcement of law and order under all areas of federal law.
11. Improving the quality of Maritime Law enforcement coordination and involvement of National Maritime elements in all maritime duty to ensure Malaysia's sovereignty and the security of protected waters, and to safeguard

[109] PMD's website (http://www.jpm.gov.my/post/modules/pajpm/vbulletin.php?bulletin_id=58&page=1)

maritime interests against encroachment.

a) Economic Planning Unit: EPU

The Economic Planning Unit (EPU) in the Prime Minister's Department is responsible for formulating a national development plan, preparing its interim report (Mid-term Review and Evaluation), and appropriating individual ministerial budgets based on revenues estimated together with Ministry of Finance and the central bank. In allocating budgets to the ministries, federal government agencies and state governments, EPU issues "Development Expenditure Requests" for which these organizations make their respective budget proposals in line with development projects they wish to implement. [110]

In relation to aging issues, EPU is mandated with budget allocation to agencies such as KPWKM, MOH, the Ministry of Human Resources, and the Senior Citizens Technical Committee. Also, it serves as a liaison with international aid agencies to implement development programs and projects.

2) Performance Management and Delivery Unit: PEMANDU

In 2009, the Najib administration set forth "One Malaysia, People First, Performance Now" as a national goal to unify Malaysia beyond racial boundaries. This became a pillar of a new national economic policy called "New Economic Model" targeting 2011 through 2020. Subsequently, the Performance Management and Delivery Unit (PEMANDU) was established within the Prime Minister's Department so as to manage and supervise GTP, mentioned in Section 2.1. In relation to aging policy, PEMANDU coordinates and promotes the related ministries and institutions concerning special policy issues such as elderly care facilities.

3) Implementation of Coordination Unit (ICU) /Jabatan Perdana Menteri (JPM) [111]

The Government Transformation Programme requires holistic involvement from an agency at the centre to facilitate and coordinate all of the national development effort. In this regard, ICU has been established and will continue taking proactive steps as the forefront agency in ensuring that national development outcomes will be realized in accordance with the needs of citizens and stakeholders. [112]

On March 15th 2005, the cabinet decided that ICU will lead in implementing the Outcome Monitoring Program, which emphasizes the output and impact of projects carried out by

[110] Takashi, Torii (2005) "A New Stage of the Development Administration in Malaysia: Focusing on its Institutions and System" RIETI Discussion Paper 05-J-008: RIETI.
[111] ICU, (2013)."Department Profile". Retrieved from http://www.icu.gov.my/pg/1icu.php?pg=info_k&type=profil
[112] ICU, (2011)."Annual Report 2011".Retrieved from http://www.icu.gov.my/pdf/laporan/laporan_2011.pdf. p.5

government agencies at each level, such as federal, state and statutory bodies. [113]

Indeed, ICU JPM was entrusted with execution of some major projects for the country's development such as *Tunas Mekar,* which promotes family industry in rural communities, and One District One Industry (SDSI). Moreover, ICU (JPM) has been entrusted with execution of Basic Infrastructure Projects (PIA), Public Infrastructure Projects (PIAS) and Rural Industry Projects. [114]

In 2007, the ICU JPM is accountable as the main coordinator for the People Welfare Program, previously known as the Poverty Eradication Program, which will be handled and administered by the Social Well Being division.

In line with this objective, eKasih has been introduced as a database system that keeps all of the records and data of poor families at the national level to plan, implement and monitor poverty programs. EKasih enables government to identify and record all poor and hard core poor families for monitoring purposes. Data and information recorded into eKasih are based on the Census of Poor Households (BIRM) which has been conducted by part-time enumerators appointed by Department of Statistics (DOS), with census results submitted to the ICU as a key input to eKasih. [115] There are over 300 part-time enumerators among local citizens, hired and trained by DOS and deployed in ICU state offices nationwide. [116]

i. Main Core Business

1. Coordination, monitoring and evaluation the implementation and outcome of Programme / Project Malaysia Five-Year Development Plan (RMLT).
2. Management, implementation and monitoring the allocation of Prime Minister Program / Special Projects.
3. Coordination, monitoring and evaluation of programs / projects for People's Welfare.

ii. Core Business

1. Coordination, implementation, monitoring and evaluation of Project Infrastructure Maintenance and Maintenance of Public Infrastructure Projects under the provisions of the Ministry of Finance.
2. Coordination and monitoring the effectiveness of policies and strategies for the One Village One Product program.

---

[113] ICU, (2013).“History”.http://www.icu.gov.my/pg/1icu.php?pg=info_k&type=sejarah
[114] ICU, (2013).“History”.http://www.icu.gov.my/pg/1icu.php?pg=info_k&type=sejarah
[115] Ministry of Women, Family and Community Development, (2013). “eKasih”. Retrieved from http://www.kpwkm.gov.my/ekasih
[116] Implementation Coordination Unit, Prime Minister's Department, (2013). “eKasih National Databank of Poverty Malaysia”. Retrieved from http://www.icu.gov.my/pdf/artikel/ekasih_info.pdf

3. Serve as the secretariat for the coordination of the implementation machinery under Directive No. 1, 2010 and main government meetings.
4. Coordination and monitoring the effectiveness of policies and strategies of the Federal Statutory Bodies (MDS) based on circular-related papers.
5. Coordination and monitoring the effectiveness of policies and strategies Restructuring Society of Penang Bumiputera Participation and the Penang Regional Development Authority (PERDA).

iii. Vision

An ideal and effective central agency to monitor the implementation of the national development plan

iv. Mission

A central agency that drives national development through coordination, identification and evaluation of policies, programs and projects by applying outstanding work culture and good management practices.

a) Social Wellbeing Division [117]

The Society Wellbeing Division is one of the divisions of the Implementation Coordination Unit, in the Prime Minister's Department, that is responsible for overseeing and organizing all Poverty Eradication Program. The Society Wellbeing Division is comprised of three sections:

1. Programme and policy coordination
2. Operation and data management
3. One district one industry program coordination

The functions of this division are:

1. To coordinate, plan, monitor and evaluate policy implementation, in addition to giving feedback on programs or projects related to economic growth, living standards, and poverty eradication in urban and rural areas under the Society Wellbeing Program.
2. To coordinate, plan, implement, monitor and evaluate the usage of and provide assistance to information updating through eKasih data as the primary reference in implementing poverty eradication programs or projects.

[117] ICU, (2013).“Social Well-being Department”. Retrieved from http://www.icu.gov.my/pg/1icu.php?pg=info_k&type=bhgn&list=b_sr

3. To coordinate, monitor and evaluate the implementation of One District One Industry (SDSI) program at ministry, state and district level.

Table 2-14 Budget for ICU

	2010	2011	2012	2013
Budget (MYR)	571,238,700	690,457,100	567,250,000	588,650,00
Staffs	1,421	1,378	1,363	1,363

Table 2-15 Budget for NKRA: Low Income Household

No	Program	2010 Expenditure (MYR)	2011 Expenditure (MYR)	2012 Expenditure (MYR)	2013 Expenditure (MYR)
1	NKRA: Low Income Household	-	265,000,000	230,000,000	200,000,000

Source:
Federal Government Budget 2013 [118]
Federal Government Budget 2012 [119]
Federal Government Budget 2011 [120]

(5) Ministry of Human Resource (MOHR) [121]

a) Role

The Ministry of Human Resources Malaysia is responsible for developing a competitive workforce and promoting social justice among workers in Malaysia. The Ministry ensures that human resources policies enacted are practical and are high-quality. Besides that, the ministry also ensures contact and cooperation between the departments and agencies under the Ministry, so that employers and employees are always strong and harmonious. [122]

i. Vision

[118] Ministry of Finance, (2013).“Federal Government Budget 2013, Prime Minister’s Department”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b6.pdf
[119] Ministry of Finance, (2012).“Federal Government Budget 2012”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap1.pdf
[120] Ministry of Finance, (2011).“Federal Government Budget 2011”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf
[121] http://www.mohr.gov.my/index.php?option=com_content&view=article&id=699&Itemid=420&lang=en
[122] Ministry of Human Resource, (2011).“Annual Report 2011”. Retrieved from http://www.mohr.gov.my/docz/publication/KSM_AR.pdf

To be the leading agency in the development and management of a world class workforce.

ii. Mission [123]

1. To develop a workforce that is productive, informative, disciplined, caring and responsive to the changing labor environment, towards increasing economic growth and hence creating more job opportunities.
2. To encourage and maintain conducive and harmonized industrial relations between employers, employees and trade unions for the nation's economic development and wellness of the people.
3. To uphold social justice and ensure harmonious industrial relations through solving industrial disputes between employer and employee and awarding collective agreement.
4. To ensure that trade unions practice democracy, are orderly and responsible in their efforts to contribute to achieving the objective of industrial harmony.
5. To be the leader in development of nation's human resources.
6. To ensure that safety and health of workforce is assured.
7. To develop a skilled, knowledgeable and competitive workforce in harmonious industrial relations and with social justice.

iii. Roles and Responsibilities [124]

1. To update and implement labor policies and laws to create an efficient, productive and disciplined workforce with positive values and good work ethics.
2. To update and implement occupational safety and health policies and laws to ensure a healthy and safe work environment.
3. To efficiently manage and independently resolve industrial disputes between employer and employee in order to create a conducive work environment.
4. To monitor and facilitate development and movement of trade unions so they are orderly, for the benefit of the nation.
5. To manage international relations in labor management field, technical co-operation in labor-related matters and human resources development.
6. To encourage and coordinate tripartise among employees, employers and Government, and to create harmonized relation toward Vision 2020.
7. To plan and develop human resources through control and labor market analysis to

[123] Ministry of Human Resource, (2012).“Vision and Mission”. Retrieved from http://www.mohr.gov.my/index.php/en/about-us/vision-mission
[124] Ministry of Human Resource, (2012).“Roles and Responsibilities”. Retrieved from http://www.mohr.gov.my/index.php/en/2012-11-01-21-01-13/roles-and-responsibilities

formulate policies relating to employment, development of a skilled workforce and productivity-linked wage system.

8. To create job opportunities and conduct job placement.
9. To update and implement National Vocational Training Policy and strategies that will fulfill training needs in the private sector.
10. To revise, update and develop the syllabus of skills training (NOSS), Skills Certification System (MOSQ) and skills standards for implementation.
11. To update and effective implement social safety facilities to ensure a sufficient safety net for workers.

In relation to aging society issue, in 2012 the Ministry of Human Resource has proposed a retirement age extension plan. A Minimum Retirement Age Act 2012 has been enacted in appreciation to the private employees. Thus, employees can keep being productive and continue contributing to the society until they reach the age of 60 years old.

(6) Ministry of Finance [125]

The Ministry of Finance is a Federal Government Ministry in Malaysia.

i. Vision

To be the premier agency responsible for the management of the nation's finances and economy.

ii. Mission

To manage the nation's finances and economy effectively, transparently and efficiently to achieve the nation's development goals.

iii. Motto

Driving the economy through excellent financial policies.

iv. Objective

- Ensure sustained and continuous economic growth.
- Strengthen national competitiveness and economic resilience.
- Ensure effective and prudent financial management.
- Pursue a more equitable sharing of national wealth.
- Improve quality of life and well-being of society.

[125] Ministry of Finance, (2010).“Treasury Profile”. Retrieved from http://www.treasury.gov.my/index.php?option=com_content&view=category&id=120&Itemid=160&lang=en

v. Function

- To formulate and implement fiscal and monetary policies in order to ensure effective and efficient distribution and management of financial resources.
- To formulate financial management and accounting processes, procedures and standards to be implemented by all Government agencies.
- To manage the acquisition and disbursement of federal Government loans from domestic and external sources.
- To monitor Minister of Finance Incorporated companies to ensure that they are managed effectively.
- To monitor the financial management of Ministries, Government Departments and Statutory Bodies.
- To formulate and administer policies related to be the management of Government procurement.
- To formulate policies and administer Government housing loans for public sector employees.

1) Budget Management Division [126]

In relation to aging society issues, the Budget Management Division is in charge of and formulates all budget allocations in effective as well as efficient ways. This division will review the entire estimated budget of all government agencies. Moreover, this division will review all planned program and estimated budgets of each ministry. There is a special unit called Women, Family and Community Development Unit under the Social Sector Budget Management Division that is in charge of formulating and reviewing the entire budget for the Ministry of Women, Family and Community Development. [127] In general, there are about 100 government servants working in this department, although only 3 people are in charge of the Women, Family, and Community Development Unit.

i. Vision

To formulate an efficient and effective budgeting system to meet the requirements of the national economy

ii. Mission

[126] Ministry of Finance, (2013).“Budget Management Division”. Retrieved from http://www.treasury.gov.my/index.php?option=com_content&view=article&id=398%3Abelanjawan&catid=123%3Abahagian-di-perbendaharaaninfoperhubungan&Itemid=152&lang=en

[127] Ms.ShyamalaJohthi, (2013). Assistant Director, Unit Women, Family and Community Development, Budget Management Division. Phone Interview

We strive to ensure that the financial resources of the country are allocated and utilized in the most effective and efficient manner.

iii. Objective

To ensure that all government agencies are provided appropriate financial allocation through the examination and analysis of programmes and development plans in accordance with the current national budget policy.

iv. Function

- To ensure the distribution of Federal funds is carried out according to national policies and objectives.
- To ensure that allocations provided to Ministries and Departments are expended efficiently and effectively.
- To process and approve financial grants to the State Governments and Local Authorities as provided for under the Federal Constitution and in accordance with decisions of the National Finance Council and the Cabinet.

(7) Ministry of Housing and Local Government

In relation to aging society issues, the Ministry of Housing and Local Government was established on 24 May 1964 as the Ministry of Local Government and Housing. Following a Cabinet reshuffle on 18 July 1978, the Ministry was renamed the Ministry of Housing and Local Government. This was the result of a merger between the Ministry of Housing and Rural Development and the Department of Local Government, which was previously part of the Ministry of Local Government and Federal Territories.

1) Federal Department of Town and Country Planning [128]

The Federal Department of Town and Country Planning is one of the departments that has been put under the jurisdiction of the Housing and Local Government Ministry to be directly involved in all issues related to town and country planning at the federal level.

i. Vision

To become the leader of town and country planning, working towards creating quality, flourishing and sustainable living environment by 2020

[128] Federal Department of Town and Country Planning Peninsular Malaysia.“Vision, Mission, Quality Policy and Objectives”. Retrieved from http://www.townplan.gov.my/en_content.php?ID=19

ii. Mission

To spur national physical planning through the implementation and monitoring of comprehensive, systematic and innovative development plans towards the well-being of society.

iii. Objectives

1. To strengthen the physical, social and economic development system in urban and rural areas in order to uplift the quality of life, in accordance with the nation's objectives.
2. To plan, control and co-ordinate development, land use and land conservation through effective implementation of the Town and Country Planning Act (Act 172) and related acts,
3. To formulate and implement planning regulations, policies, plans and guidelines as well as to ensure effective adoption by all agencies at the implementation stage.
4. To ensure high-quality town planning services and satisfactory information systems for long-term planning needs.

In ensuring the ideal use, development, and conservation of land, the functions of the Federal Department of Town and Country Planning have been divided into three levels of government: federal, state and local. Further descriptions of their mandates are as below;

i) Functions at Federal Level

1. To advise the Federal Government in all planning matters that are related to the use and development of land.
2. To act as the Secretariat to the National Physical Planning Council that was formed under the Town and Country Planning Act 1976 (Act 172).
3. To encourage comprehensive, effective and efficient planning systems through planning laws, methodologies, research, standards, procedures and planning rules.
4. To translate national socio-economic policies into physical and spatial strategies/form based on land use formulas and settlement programmes,
5. To assist the state governments, local authorities and government agencies in preparing Development Plans, i.e. State Structure Plan, District Local Plan and Special Area Plan.
6. To monitor, update and publish statistics, bulletin and rules related to town and country planning.

In short, the Federal Department of Town and Country Planning of Peninsular Malaysia (Headquarters) and its regional branch offices undertake planning, spatial planning, preparation of development plans, management services of technical resources, planning and monitoring of public parks, landscaping planning and support services.

ii) Functions at State Level

1. To serve as the main advisor to the state government in all planning matters, including use and development of land.
2. To act as the Secretary to the State Planning Committee formed under the Town and Country Planning Act 1976 (Act 172).
3. To advise local authorities regarding the policies on and control of land use and buildings.
4. To regulate development in the states, including approvals and monitoring of development plan implementation.
5. To assist state government in preparing layout plans for special projects for the state; and
6. To conduct research and studies on land use and development.

The Federal Department of Town and Country Planning is the main advisor to the State Government in all aspects governing town and country planning. It is responsible for formulating land use policies and preparation of development plans for various sectors such as housing, industries and tourism. These departments also render advice to the local authorities for purposes of development control. This is carried by the preparation of layout plans to coordinate developments, preparation of town plans, and vetting of development proposals submitted by private developers to the local authorities. The State Town and Country Planning Department is also the Secretariat to the State Planning Committee (SPC), set up under the Town and Country Planning Act 1976.

iii) Functions at Local Level

1. To plan, coordinate and control the use and development of land and buildings in the local authorities' area.
2. To facilitate, assist and encourage the collection, upkeep, and publication of statistics, bulletins, monographs, and other publications that are related to town and country planning and its rules,
3. To perform other related tasks entrusted by the State Authority or the State Planning

Committee. [129]

The planning departments of the major local authorities are independent of the other two levels. Local authorities with well-established planning departments handle all matters related to town planning, including control, project planning and preparing local lay out plans. [130]

The Research and Development Division under Federal Department of Town and Country Planning has been formed for the purpose of securing quality and efficiency in town and country planning services at all levels of the government. This is based on findings and conclusions of research studies which are comprehensive, innovative, progressive, sustainable and scientific. [131] The Research and Development Division is the responsible authority that issues the Planning Guidelines for Universal Design (GP015-A) at the federal level, for the benefit of PWDs and the elderly. In total there are 40 staff in this division at the federal level. These guidelines are explained in detail in 5.3. (8).

Table 2-16 Budget for Operating Expenditure and Development Expenditure for Ministry of Housing and Local Government

Year	Operating Expenditure (MYR Million)	Development Expenditure (MYR Million)
2009	1,196	1,062
2010	1,085	1,887
2011	1,596	1,137
2012	1,627	1,586
2013	1,972	1,166

Note: Data for 2009-2011 are real expenditures, while data for 2012-2013 is estimated expenditure.
Source: Ministry of Finance Malaysia. [132]

[129] Town and Country Planning Department.“Department Function”. Retrieved from http://www.townplan.gov.my/en_content.php?ID=20
[130] Town and Country Planning Department, (2013).“Department Function”. Retrieved from http://www.hbp.usm.my/townplg/jpbd/jpbd.htm
[131] Ministry of Housing and Local Government.“Research and Development Unit”. Retrieved from http://www.townplan.gov.my/en_content.php?ID=112
[132] Ministry of Finance, (2013).“Federal Government Budget 2013, Ministry of Housing and Local Government”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b43.pdf

Table 2-17 Number of Staff and Budget for Research and Development Division

	2010	2011	2012	2013
Budget (MYR)	10,307,300	9,940,900	11,726,700	12,182,600
Staffs	162	162	147	147

Source:
Federal Government Budget 2013 [133]
Federal Government Budget 2013 [134]
Federal Government Budget 2013 [135]

(8) Ministry of Transport

In general, the Ministry of Transport jurisdiction covers the areas of aviation, maritime and land transport. For PWDs and elderly-related matters, it involves the Land Division and Research and Planning Unit.

1) Research and Development Unit

The Research and Development Unit is the representative of the Ministry of Transport in The National Council for person with disabilities (PWDs). National Council for PWDs is established to promote and develop the quality of life and wellbeing of PWDs by providing support in the areas of accessibility, rehabilitation, health, protection of persons with severe disabilities and situations of risk and humanitarian emergencies. Thus, all issues related to transportation or standards that are suitable for PWDs will be discussed by the Research and Development Unit with assistance from the Road Transport Department of Malaysia, specifically the Automotive Engineering Division.

2) Automotive Engineering Division, Road Transport Department [136]

The Automotive Engineering Division under the Road Transport Department of Malaysia is the main body responsible for reviewing and developing Guidelines for Universal Access Buses, as well as the Land Public Transport Master Plan. The job specifications of the Automotive Engineering Division are stated below:

1. Coordinate and regulate the inspection quality and standards at PUSPAKOM, which is

[133] Ministry of Finance, (2013).“Federal Government Budget 2013, Ministry of Housing and Local Government”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b43.pdf
[134] Ministry of Finance, (2012).“Federal Government Budget 2012”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap3.pdf
[135] Ministry of Finance, (2011).“Federal Government Budget 2011”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf
[136] Road Transport Department Malaysia, (2013). Retrieved from http://www.jpj.gov.my/web/guest/fungsi-utama

an automotive maintenance company under the Automotive Engineering Division.

2. Coordinate and monitor the legal and technical standards of vehicles.
3. Manage the approval of change of engine and chassis, commercial vehicle construction plans, light transparency and others.
4. Work as Research and Development Centre for Automotive Engineering.

Hence, the Automotive Engineering Division is the central body that prepares and reviews guidelines about public transportation, including universal design and features for elderly and PWDs.

Table 2-18 Budget for Operating Expenditure and Development Expenditure for Ministry of Transport

Year	Operating Expenditure (MYR Million)	Development Expenditure (MYR Million)
2009	924	3,158
2010	1,142	2,736
2011	1,240	3,962
2012	1,134	4,159
2013	1,134	4,478

Note: Data for 2009-2011 are real expenditures, while data for 2012-2013 is estimated expenditure

Source: Federal Government Budget 2013 [137]

Table 2-19 Expenditure for Research and Development Unit

	2010	2011	2012	2013
Budget (MYR)	624,200	792,000	1,120,500	1,191,000
Staffs	16	16	16	16

Source:
Federal Government Budget 2013 [138]
Federal Government Budget 2012 [139]
Federal Government Budget 2011 [140]

[137] Ministry of Finance, (2013).“Federal Government Budget 2013, Ministry of Transport”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b28.pdf
[138] Ministry of Finance, (2013).“Federal Government Budget 2013, Ministry of Transport”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2013/b28.pdf
[139] Ministry of Finance, (2012).“Ministry of Transport Annual Budget”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2012/ap2.pdf
[140] Ministry of Finance, (2011).“Ministry of Transport Annual Budget”. Retrieved from http://www.treasury.gov.my/pdf/bajet/maklumat_bajet_kerajaan/2011/anggaran_perbelanjaan2011.pdf

(9) Inter-agency Coordination

Respective ministries have state- and local-level agencies. Inter-agency coordination at the federal level is pursued by ICU and EPU, while District Officers work for local-level coordination. [141] The chair of the State Development committee is selected from state governors or commissioners of the executive committee. The committee plays a role in coordinates each department to achieve their tasks in line with the decisions made by the executive committee, because the committee members are made up of different institutions such as state departments, federal regional departments, and so forth. The committee does not have any direct authority to each related institution and acts simply as a coordinator among these stakeholders.

Administration of aging issues at the district level falls under the District Officer. Each district has a committee for the elderly, as well, and this committee plays a coordination role.

(10) Aging-related Agencies at the Local Government Level

Generally, the local government has no direct involvement in providing social welfare services. State agencies of the Social Welfare Department carry out all activities regarding social welfare, including care services for older persons.

1) State Development Committee for Older Persons and District Development Committee for Older Persons

The State Development Committee for Older Persons is set up to link the federal administration with the state. The chairperson of this committee is the Deputy Secretary of State, whereas the State Welfare Department acts as the Secretariat.

Members in the State Development Committee for Older Persons consist of government agencies, private sectors and non-governmental organizations. The same mechanism is suggested for the district level and called the District Development Committee for Older Persons. Every State Development Committee for Older Persons must prepare an annual plan to implement the National Action Plan for Older Persons according to priorities in each respective state. These are then presented to the Technical Committee.

On the other hand, the district development committee for older persons/local authorities are be chaired by the Chief Assistant District Officer and the District Social Welfare Office as the secretariat. Members of this committee consist of government agencies, private and non-governmental organizations, ruler and individuals who are actively involved in the development of the local older persons. The secretary of this committee is under the

[141] Referring to The Council of Local Authorities for International Relations (CLAIR) website (http://www.clair.or.jp/j/forum/c_report/pdf/313.pdf)

Community Development Officer. [142]

2) Education and Spirituality Subcommittee [143]

Objectives and major functions of the Education and Spirituality Subcommittee under Ministry of Education are summarized as follows.

i. Main goals

1. Empower individuals, families and communities by providing services that are elderly-friendly, efficient, and effective in developing the environment to help senior citizens to live peacefully and productively in the country.
2. Foster the values, attitudes and practices that build mutual respect, love and appreciation for fellow human beings.
3. Leverage the knowledge, expertise and experience of the elderly to enhance spirituality, personality and self-esteem among the students and the youngsters.

ii. Functions

1. Taking action following the decision of Senior Citizen Advisory and Consultative Council.
2. Planning the implementation of the programs and activities related to the National Action Plan for Senior Citizens.
3. Establishing coordination between government ministries, agencies and non-governmental organizations in implementing the programs and activities related to the National Action Plan for Senior Citizens.
4. Monitoring programs and activities undertaken by the Member Implementation Committee at the Ministry, State, District and School level.
5. Making an assessment of the programs and activities implemented for improvement.
6. Preparing a report to the Senior Citizen Advisory and Consultative Council.
7. Steering Committee meeting will be held twice a year and Implementation Committee meeting will be held three times a year according to agreed schedule and dates.

iii. Job scope

[142] Esah bt Kelling, (2013). Assistant Director, Senior Citizens and Family Unit, Social Welfare Department. Phone interview.
[143] Ministry of Education, (2011).“Term of Reference for Education and Spirituality Sub Committee”. Retrieved from http://www.moe.gov.my/jpnselangor/v3/images/stories/Dasar%20Warga%20Emas%20Negara/TERMA%20RUJUKAN%20JK%20KECIL%20%20Pendidikan911112.30PM_Edit%20KSU_FS%20Fi.pdf

1. This subcommittee is divided into the Main Committee and Implementation Committee.
2. The subcommittee will carry out programs and activities that can provide benefits to students, teachers, students from the Institute of Teacher Education, colleges and institutions of higher learning, lecturers and senior citizens, reciprocally.
3. The subcommittee will plan programming and human development activities, co-curricular activities and sports available in schools, the Institute of Teacher Education, colleges and institutions of higher learning to be aligned with strategy promotion and advocacy for inclusion and solidarity between generations.

iv. Target Group

1. Students of primary and secondary schools as well as students from colleges, the Institute of Teacher Education and institutions of higher education.
2. Senior citizens in elderly care centres, regardless of race.
3. Senior citizens in residential areas, regardless of race.
4. Senior citizens identified as meritorious and outstanding in various certain fields.

v. Education and Spirituality Program under National Senior Citizens Action Plan

1. Promote volunteerism in elderly care centres.
2. Promote the elderly as national assets and cultivate values of respect towards the elderly through:
   - Elderly adoption program - Students from the Institute of Teacher Education, colleges, higher education institutions, elderly persons and local communities.
   - Organize “Day between Generations” - School children / Institute of Teacher Education / Colleges / higher education institutions, senior citizens, government agencies, non-government organization and local communities.
   - Organize healthy aging between generation’s program - senior citizens and Local communities.
   - Campaign respecting the elderly - School children / the Institute of Teacher Education / College / higher education institutions.
3. Cultivate elderly participation in school activities
   - On “Day between Generations”, School children / the Institute of Teacher Education / College / higher education institutions and the elderly have a chance to talk and discuss.

3. Care Giving Activities and Preventive Approaches

3.1. Outline

In Malaysia, government policies for care giving for the elderly and the activities to prevent them requiring care can be grouped into two major categories. One is services provided for the elderly who need support or care either in special facilities or at home (facility services and home visit services). The other is support for the elderly who have ability to care for themselves so that they can achieve social participation and find motivation in life.

The major organizations involved in these activities are the Ministry of Women Affairs and the Ministry of Health, as well as private companies and NGOs (as service providers) and university research institutes (as research and study institutes). While private companies provide paid services and operate their business based on revenue from services, the NGOs usually provide their services for free and carry out their activities with financial grants and donations from the government. While the Ministry of Women Affairs is in charge of policymaking, the Ministry of Health is engaged in medical-related matters. Some major organizations are actively involved in legislation also, as exemplified by NGO's participation in national councils, and universities' research institutions' providing advisory support to the authorities.

3.2. Major Organizations (Public Institutions, Private Companies, NGOs, etc.)

(1) Roles and Functions of Major Organizations

1) UPM: Institute of Gerontology, University Putra Malaysia [144]

i. Objectives and Background of the Establishment

UPM was established in 2002 as a research institute that studies and researches aging issues. The institute consists of two research departments, one is Social Gerontology and the other is Medical Gerontology. It does not have any faculties and the research departments have post graduate members only.

ii. Mission

UPM has implemented various research projects relating to aging. EPU, as well as other

[144] On-site hearing survey on April 23, 2013 (UPM)

Ministries and Departments, seeks advice from UPM for legislation and assessment of government policies.

UPM uses publicly offered funds for its research activities. Seventy percent of its research funds are provided by domestic institutions and thirty percent by international institutions. Among the domestic institutions, the main contributors are the Ministry of Science and Technology and the Ministry of Higher Education.

2) ADFM: Alzheimer's Disease Foundation Malaysia [145]

i. Objectives and Background of the Establishment

The Alzheimer's Disease Foundation Malaysia is a non-profit organisation set up to promote awareness of Alzheimer's Disease in Malaysia, and to help dementia patients and their families living in Malaysia.

The idea of setting up an Alzheimer's Disease Foundation of Malaysia was first aired in 1996 by a member of the Rotary Club of Shah Alam (RCSA), Selangor, whose mother is an Alzheimer's patient. The Alzheimer's Disease Foundation was registered in August 1997 and obtained tax-exemption status in September, 1999.

ADFM implements its activities based on the contributions from RCSA, the founder of ADFM, and other organizations. It is not subsidized by the government of Malaysia. This is because the foundation has a policy to perform its activities without being influenced by the intent of the government.

The foundation is currently operating a training centre of ADFM Asian Branch in Johor Bahru. The purpose is to prepare for establishing a facility where Filipino, Indonesian, and Malaysian caregivers are trained.

Also in 1998, ADFM became a provisional member of Alzheimer's Disease International (ADI), the umbrella organisation of national Alzheimer's associations around the world.

ii. Mission

In order to raise awareness about Alzheimer's Disease, the foundation is promoting the dissemination of correct knowledge about the disease. For example, communicating that progression of the disease can be slowed and the QOL of the patient may be maintained by early detection of symptoms and through appropriate care. Another example is the message that there are several patterns of symptoms. ADFM also provides support to caregivers by

[145] Alzheimer's Disease Foundation Malaysia, (2013). Retrieved from http://www.adfm.org.my/Home/foundation, On-site hearing survey on March 31, 2013 (ADFM)

offering a place where they can exchange ideas and interact with each other.

Specifically, the foundation's activities include: [146]

- Media exposure and public education forums such as talks, workshops and exhibitions.
- Practical and emotional support through Alzheimer's support groups, and helpline and counselling services.
- Guidance and training to relatives, professionals and volunteers involved in the care and treatment of patients with Alzheimer's and other forms of dementia.
- Dissemination of information and sharing of emotions and other experiences through newsletters, fact sheets, publications and other resource materials.
- Care giving services and facilities like day-care centres, respite centres, nursing homes, sitting services etc.
- Reference lists of medical specialist services and facilities throughout the country; and
- Fundraising activities to raise funds for ADFM's planned projects and program activities.

3) National Council of Welfare and Social Development Malaysia: NCWSDM/MAKPEM [147]

i. Objectives and Background of the Establishment

Along with the establishment of the Social Welfare Department in 1946, a national Voluntary Welfare Organisation "Central Welfare Council" has been established in this country. It is the forerunner to the National Council of Welfare and Social Development Malaysia. The objectives were to help needy people during Second World War and other victims of social problems, as well as acting as a coordinator to other welfare organizations.

Following with the establishment of Malaysia, the Ministry of Social Welfare has taken the initiative to create a national coordinating body for voluntary welfare organizations. The purpose is not only to bring them under one umbrella, but also strengthen their position in the international arena in the field of social welfare and development. In addition, this organization also has links to international organizations through its membership.

MAKPEM, as a non-governmental organization, coordinates activities of social welfare-related NGOs operating in Malaysia. Among the 52 organizations registered with MAKPEM, 14 operate in a specific state, while the remaining 38 provide their services nationwide. Each organization has multiple grass-roots NGOs under them, numbering about 350 in total. These grass-roots NGOs do not have direct relationships with MAKPEM. The

[146] ADFM, (2011). "ADFM Newsletter Sharing".

[147] National Council of Welfare and Social Development Malaysia, (2013)."Objectives". Retrieved from http://www.ncwsdm.org.my/sejarah.html, On-site hearing survey on April 18, 2013 (MAKPEM)

chairperson of MAKPEM is elected every three years by the member organizations.

The budget of MAKPEM consists of administrative expenses of MYR 300,000 and training course operation expenses of MYR 500,000. Personnel expenses are included in the administrative expenses, while the training course operation expenses include costs for venues, food and drink, lecturers and instructors, and insurance premiums associated with the training courses. Among the administrative expenses of MYR 300,000, MYR 80,000 is granted by the government and the entire training course operation expenses are also borne by the government. This makes MAKPEM the only organization in Malaysia that trains and develops human resources to be engaged in social welfare with regular financial grants from the government. Although other NGOs receive financial grants as well, they are all on ad-hoc basis and therefore they raise funds by themselves through charity and philanthropic activities.

The vision of MAKPEM is as follows.

a) Vision

- Enhance the development and well-being of Malaysians, especially less fortune individuals, and other members of the community, or communities involved with social problems that occur from time to time.
- Create a harmonious and caring environment so that every individual can live independently, in health, and productively in accordance with the rights and responsibilities of all people.

b) Mission [148]

- Mobilize and encourage all voluntary organizations in Malaysia to be involved with the issues of social development.
- Achieve excellence and superior services in social work through social policies, planning, education and training.
- Work in partnership with the public sector, the private sector and the general public.

c) Objectives [149]

1. Serve as the main body to all registered members of welfare and community development organizations and become the main representative body for them at the

[148] National Council of Welfare and Social Development Malaysia, (2013).“Vision and Mission”. Retrieved from http://www.ncwsdm.org.my/wawasan.html

[149] National Council of Welfare and Social Development Malaysia, (2013).“Vision and Mission”. Retrieved from http://www.ncwsdm.org.my/wawasan.html

national and international levels.

2. Assist and complement the government's efforts in the field of welfare and community development, and share views on current social issues for the public good.
3. Collaborate with all members to enhance and strengthen welfare activities and community development in order to address the current social problems in the country.
4. Help improving the quality of its members' work.
5. Strive to implement community development projects and research on the needs and problems of welfare and community development.
6. Provide a regular media platform for information exchange and dissemination of information among social welfare agencies.
7. Endeavour to obtain sufficient financial resources, either through contributions or donations, in order to implement programs and activities. Promote and support members in their fundraising activities so as to create a stronger social movement. All donations from the public must get approval from the Registrar of Societies in advance.
8. Organize and implement any programs and activities deemed to be fit and beneficial to the development of the National Council and its members.
9. Affiliated with international bodies and regional legitimate registered with the same goal.

4) National Council of Senior Citizens Organizations Malaysia: NACSCOM [150]

i. Objectives and Background of the Establishment

The National Council of Senior Citizens' Organisations, Malaysia (NACSCOM) is a tax-exempt, non-profit organisation founded in 1990. Its membership consists of 44 senior citizen associations, with a total of about 18,000 members (as of October 2008). NACSCOM advocates for the development of policies, programmes, projects and services that could enhance the quality of life and well-being of senior citizens (or older persons) in Malaysia.

Mission

To advocate the development of policies and services that will enhance the quality of life and well-being of older persons in Malaysia.

i. Objectives

[150] On-site hearing survey on March 18, 2013 (NACSCOM）, NACSOM, (2013). "Mission". Retrieved from http://www.nacscom.org.my/web/index.php?option=com_content&task=view&id=25&Itemid=39、The Star Online, (2012). "Educate children to care for parents, say groups". Retrieved from http://thestar.com.my/news/story.asp?sec=nation&file=/2012/10/9/nation/12143277

- To encourage and support senior citizens to enable them to remain in the mainstream of society and to continue to live their lives to the fullest and to give recognition to their contributions to the nation.
- To recognize, promote, instil and maintain the Asian family values of love and respect for our elders.
- To promote better understanding between the young and senior citizens.
- To generate community interest, support and participation in organizing programmes and activities with and for senior citizens.
- To provide opportunities for senior citizens to present their opinions and views on matters concerning them to the relevant authorities.
- To coordinate the work of various senior citizen organizations throughout Malaysia.
- To encourage and assist in the establishment of senior citizen organizations throughout Malaysia.
- To raise funds, collect, manage, and disburse funds raised for the benefit of senior citizens, old folks' homes, welfare services and other projects, subject to the prior approval of the authorities concerned. [151]

NACSCOM is linked with 53 regional senior citizen club associations. Each association is independently engaged in supportive activities for the elderly. NACSCOM sometimes represents its members to the government, and is involved in lobbying activities as a leading organization for the sake of the elderly.

NACSCOM is an appointed member of the National Advisory and Consultative Council on Ageing in order to assist government in promoting best services and take care of senior citizens welfare. In fact, NACSCOM is also a member of several ad hoc committees such as the Coordinating Committee on the Health of the Elderly in the state of Selangor, and the Coordinating Committee of the Celebration of World Health Day, Ministry of Health Malaysia. [152] In terms of international affiliations, NACSCOM is affiliated to HelpAge International, a global network of non-profit organizations working for disadvantaged older persons worldwide. It also has close cooperation with the International Federation on Ageing, a world organization for senior citizens. There are two full-time staff members who are the driver and operation staff.

The NACSCOM representative changed from Mr. Lum Kin Tuch, the founder of the organization and who has strong influence on the government and the elderly-related organizations (former member of the National Advisory and Consultative Council on Ageing),

[151] NACSOM, (2013). "Mission". Retrieved from http://www.nacscom.org.my/web/index.php?option=com_content&task=view&id=25&Itemid=39
[152] NACSOM, (2009)."Affiliations". Retrieved from http://www.nacscom.org.my/web/index.php?option=com_content&task=view&id=26&Itemid=40

to Dr. Kheu in May 2012. In October 2012, NACSCOM had proposed a law which allows neglected, abandoned or abused senior citizens to take action against their children. This law has been proposed with the objective of reducing the incidence of old folks being abandoned by family members. [153]

NACSCOM spends about MYR 300,000 annually. Income-wise, it receives financial grants of MYR 6-700,000 from the government every year and a little fee income from the users of the training courses they provide. Remaining expenses are covered by donations from private companies and political parties (NACSCOM sponsors dinner parties several times a year and financial contributions are included in the price of the ticket.)

ii. Activities

The initiation and implementation of programmes and projects in the following areas:

1. Income security, housing and legal affairs
2. Education and training
3. Health and medical services
4. Sports and recreation
5. Social services and welfare
6. Information and publicity
7. Fund raising [154]

Among the advocacy programmes that NASCOM has participated in since its establishment are listed below:

1. Advocating for the formation of The National Policy on Aging - 1995.
2. Lobbying the Government to establish a National Consultative Committee to implement the National Policy on Aging 1997.
3. Lobbying the Ministry of Health to establish an Advocacy Council on Health for the elderly.
4. Requesting the Ministry of Sports to formulate a national plan to promote sports for the elderly.
5. Requesting the Ministry of Transport to provide better transport facilities for the elderly.
6. Advocating to the Ministry of Housing to build three-room low cost flats to house the low income workers.
7. Promoting tourism for the elderly.

[153] The Star Online, (2012). “Educate children to care for parents, say groups”. Retrieved from http://thestar.com.my/news/story.asp?sec=nation&file=/2012/10/9/nation/12143277

[154] NACSOM, (2009).“Plan of Action”. Retrieved from http://www.nacscom.org.my/web/index.php?option=com_content&task=view&id=29&Itemid=42

8. Advocating for the building of Day Centres in all new development settlements for the elderly.
9. Advocating for the construction of more Old Folks Homes by the Government, to take care of the elderly poor throughout country.
10. Requesting the Government to build more Day Centres for the use of the elderly, a ten year plan to establish Day Centres. The Government should allocate MYR 10 million a year to build up Day Centres though the country.
11. Requesting the Government to build more health care centres to provide health services for the rural areas and the elderly poor.
12. Requesting the Government to promote a social pension welfare scheme to provide financial assistance to new elderly poor. Such poor persons should be given a social pension MYR400 per month to live economically with their families.

The main business of NACSCOM is the operation of old folk's homes, lifelong learning, and day care centres for the elderly (Please see 3.4(1)② for lifelong learning, and day care centre for the elderly).

At the old folk's homes, food and shelters are provided free of charge to the elderly who have been in a poor state for a long time without support from children. Most of the operation expenses of the old folk's homes are covered by donations, and NACSCOM is promoting campaigns to emphasize the tax benefits that private companies can receive by making donations.

There are many old folk's homes operated by other organizations as well. In Malaysia, most of the organizations that operate a great number of old folk's homes are Christian organizations.

5) Golden Age Welfare Association Malaysia:USIAMAS [155]

i. Objectives and Background of the Establishment

USIAMAS, an NGO named "Persatauan Kebajikan Usiamas Malaysia" in Malay, aims to establish a community where the elderly receive appropriate care and services to prevent them from needing care. The group also works to ensure that the elderly can contribute to a liberal and fruitful life in the community through promotion of and emphasis on respect for

[155] On-site hearing survey on March 18, 2013 (USIAMAS）, Usiamas, (2013). Retrieved from http://www.usiamas.org.my/index.htm、Metro, (2012). "Usiamas Received RM36,000 from South Korea". Retrieved from http://www.hmetro.com.my/myMetro/articles/UsiamasterimaRM36_000setahundariKoreaSelatan/Article、The Star, (2011). "Usiamas volunteers offer welcome company". Retrieved from http://thestar.com.my/lifestyle/story.asp?file=/2011/11/16/lifefocus/9563141&sec=lifefocus.

the elderly. It also tries to develop a community where the elderly can lead their life with dignity and with appropriate levels of QOL, so that they can make a meaningful contribution to the improvement of society. (A community of older persons that is caring, proactive, progressive and productive, living with dignity and enjoying quality of life, and contributing meaningfully toward the betterment of society through the promotion and reinforcement of noble values.)

For this purpose, USIAMAS tries to enhance the opportunities of the elderly as much as possible through effective implementation of study and research, empowerment, training, advocacy, and community services (To be the premier organization, empowering older persons to achieve their maximum potential through the effective implementation of research, extension, training, advocacy and community service programs).

The specific objectives of the organization are as follows:

- Draw the attention of all concerned to issues and problems faced by older persons.
- Safeguard the interests of older persons to ensure that they lead a happy and secure lives, possibly within the framework of family environment.
- Encourage family members to provide adequate care and protection for their older parents.
- Provide training and support services to family members and the general public on best practices in caring for older persons, in addition to engaging in various activities that encourage older persons to lead a more wholesome life.
- Encourage capable older persons to engage in voluntary services for the benefit of the community/family/individuals, according to their respective needs.
- Conduct academic studies on issues pertaining to older persons.
- Publish books, magazines, and newsletters as efforts to advocate and promote understanding on matters relating to ageing issues. [156]

The members of the association are those who are fifty years and above, who are still active in contributing to and mapping out activities for the community at large, regardless of race, religion and political affiliation.

In fact, membership in the association is open to all Malaysian individuals and associations. There are three types of individual membership. Those people fifty years and above age can become an ordinary member or life member. Life membership means one pays only a single subscription fee of MYR 50.00. The ordinary membership fee is MYR 20.00 annually. People who are below 50 years of age can also be members, and they are called Associated Members.

[156] Usiamas, (2012).“About us”.http://www.usiamas.org.my/mision.htm

ii. Activities [157]

The activities conducted are varied and changing from time to time depending on the resources, specifically manpower and finance. At the moment the activities are as follows:

1. Home Help Service
2. Training for the elderly: How to live optimally after retirement.
3. Promotion of Noble Values (Pronova)

The program currently being practiced by Usiamas with the most impact is the Home Help Service for Older Persons. Under this program, officially launched in June 2005, 30 volunteers were trained to provide services for 15 selected older people with the assistance of Help Age Korea, through the ASEAN Secretariat. At first, the program started out as a pilot in Klang, Selangor. When it was launched, this joint effort between Usiamas and the Department of Social Welfare Malaysia received funding from HelpAge Korea, which is affiliated with HelpAge International. Every year they receive MYR 36,000 from South Korea through the Korean HelpAge (HAK) to implement Home Help Service for Senior Citizens in the country. [158]

Then in 2011, the program was extended to Seremban, where 16 volunteers participated to help 19 elderly folks every week. Volunteers help their "charges" with grocery shopping and accompany them to the hospital for checkups, among other things. They also help to clean their homes, trim their nails, and just lend an ear to these often-lonely people. [159]

The program attracted 157 volunteers to help 105 abandoned and solitary elderly. It provides home visit care at 3 locations.

USIAMAS, when it finds a poor elderly person in the region, reports to the Social Welfare Department. Residents in local communities and their leaders sometimes recognize the existence of such people and recommend him/her to visit the Social Welfare Department as well. The Social Welfare Department checks the person's needs for financial support and services, and provides required support and services.

As for the budget of USIAMAS, the percentage of financial grants from the government is small and most of their income comes from donations and fund-raising. The organization is suffering from financial problems, insufficient numbers of staff and training issues. These are common problems seen with NGOs in this field.

---

[157] Usiamas, (2013). Retrieved from http://www.usiamas.org.my/index.htm

[158] Metro, (2012). "Usiamas Received MYR36,000 from South Korea". Retrieved from http://www.hmetro.com.my/myMetro/articles/UsiamasterimaRM36_000setahundariKoreaSelatan/Article

[159] The Star, (2011). "Usiamas volunteers offer welcome company". Retrieved from http://thestar.com.my/lifestyle/story.asp?file=/2011/11/16/lifefocus/9563141&sec=lifefocus

6) Central Welfare Council of Malaysia: CWC／Majlis Pusat Kebajikan Semenanjung Malaysia: MPKSM [160]

CWC, established in 1946, has more than 60 years of history. The organization started as a subordinate organization of the government, because there was no concept of "NGO" at that time. Then, in 1986, the organization went through a status change to become an NGO. The organization's activities are still under the supervision and guidance of the government (the Ministry of Women Affairs and Jabatan Pendaftaran Negara Malaysia, the organization under the Ministry of Home Affairs is in charge).

CWC has 78 branch offices in 12 states in Malaysia and operates 17 Day Care Centres, 102 facilities for the elderly, and home visit care services for about 1,000 people. One volunteer staff member takes care of 3 to 5 senior citizens per day and visits each home at the frequency of between once per day and once per week. CWC receives a financial grant of MYR 3 million from the government every year and a small amount of donations from the private sector.

Table 3-1 Activity Program by CWC (2011)

State	Care Service Program		Day Care Centre for the Elderly		Transportation Program by the Caregiving Team		Accommodation for Poor Student		Comprehenisve Workshop	
	Volunteer	Customer	Centre Facility	Registered Member	Number of Vehicles	Number of Members	Number of Accommodation Facilities	Number of Students	Workshop	Trainer
PERLIS	16	75	-	-	1	17	-	1	-	-
KEDAH	10	39	2	453	1	24	-	-	-	-
PERAK	12	59	1	743	1	15	-	-	-	-
PENANG	3	15	-	-	1	14	-	-	-	-
SELANGOR	16	75	2	160	1	9	3	97	-	-
K. LUMPUR	2	5	-	297	-	-	-	-	-	-
PAHANG	12	66	3	1,362	2	51	2	105	-	-
KELANTAN	19	75	1	72	1	7	8	515	-	-
T'GANU	9	45	4	339	1	5	4	123	-	-
N. SEMBILAN	6	34	1	88	-	-	-	-	-	-
MELAKA	2	22	2	35	1	18	-	-	-	-
JOHOR	-	-	1	885	1	-	-	-	1	50
SABAH	3	183	-	-	-	-	-	-	-	-
SARAWAK	6	33	-	-	-	19	-	-	-	-
Total	116	726	18	4,434	11	179	19	840	1	50

Source: Provided by the Central Welfare Council, Peninsulae Malaysia (CWC)

(2) Sharing of Roles and Responsibilities between Public Institutions and Private Sectors (Private Companies, NGOs, etc.)

Regarding care-giving and prevention of people requiring care, the government makes policies and private companies and NGOs provide services. While the government directly operates some facility services and provides support for purchase of synthetic/support tools,

[160] JICA (2012), "Malaysia", in JICA, Data Collection Survey on Social Security Sector in Asia Final Report: Country Report,7.2.5..

the target of such services is limited to the elderly who are poor/living alone.

The government maintains the quality of services provided by private companies and NGOs by regulating residential care and day care services through relevant laws and regulations. The private companies and NGOs become registered once their services satisfy the standards prescribed by the government, and then become subject to the control of the government. However, there seems to be a few hundred unregistered facilities in the nation currently.

The services provided by private companies are market oriented and mainly target high-income households. The fees for services are relatively high. Some of these operators are providing care using the know-how of industrialized companies, which contributes to the improvement of overall service quality in the market. On the other hand, the services provided by NGOs tend to be welfare-oriented and therefore they often provide free philanthropic support and services to the elderly who are poor/living alone. Their source of income is basically limited to financial grants and contributions from the government, and some NGOs inevitably have financial difficulties.

Some NGOs have become members of government councils and committees. There are also university research institutes that not only conduct studies and research, but also operate commercial businesses in this field. They are consulted by ministries and government agencies regarding policymaking. Through this structure, it is believed that information regarding the actual situation of services in the field and the results of study and research are reflected in the policymaking.

3.3. Major Services and Support

Basically, facility services and home care services are provided to the elderly who need care in their daily life. Support for social participation and finding motivation in life is provided to the elderly who have ability to care for themselves.

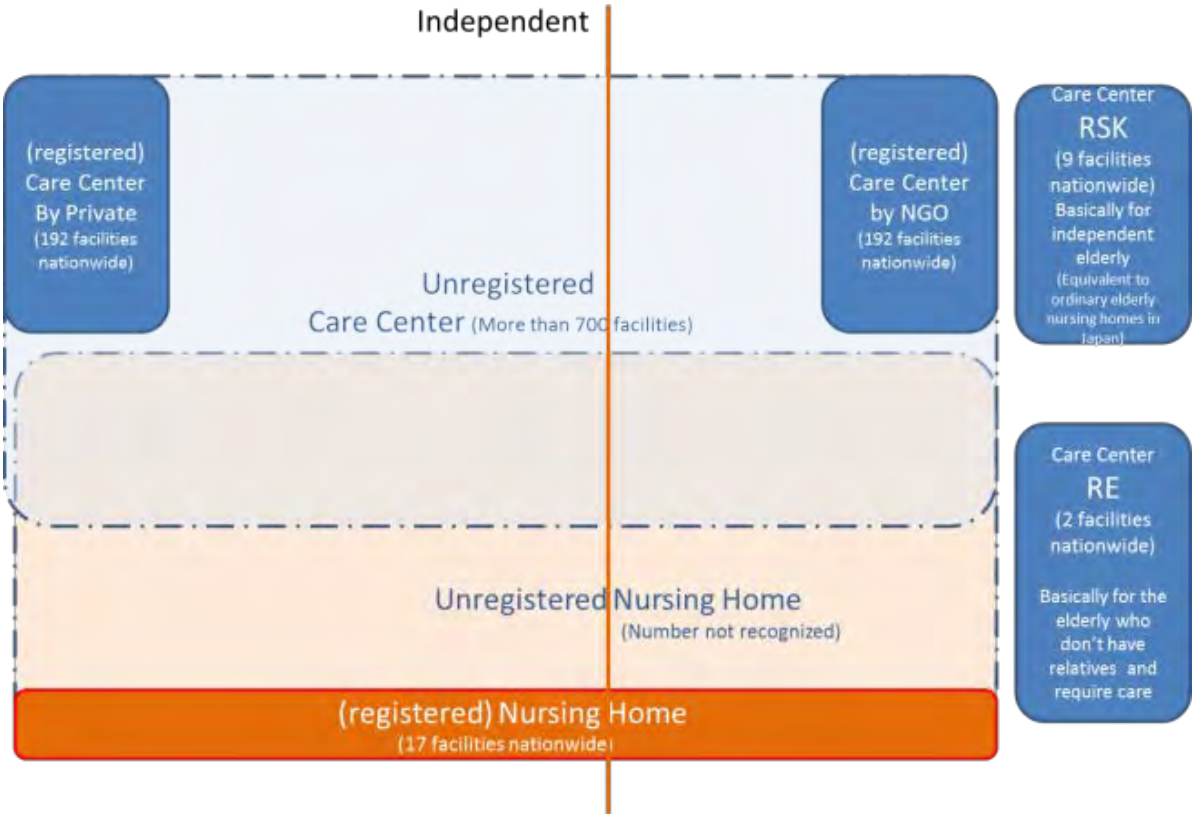
(1) Facility services

Facility services for the elderly are provided at residential care facilities operated by the government, facilities operated by NGOs or private companies, and hospitals for the elderly where patients spend time for recovery.

There are two types of residential care facilities operated by the government. One is the “Elderly Home/Seri Kenangan Home: RSK” for senior citizens in an ordinary physical state. The other is the “Home for Chronically Ill／Ehsan Home: RE” for the elderly who are chronically ill. Both are for poor citizens and the services are provided free of charge. The governing authority is the Ministry of Women Affairs. There are 9 RSKs and 2 REs in Malaysia currently. According to Deputy Women, Family and Community Development

Minister, 1,927 people were housed at public old folks homes while 4,059 were accommodated at NGO and privately operated old folk's homes.[161] In 2011, MYR 26.79 million and MYR 5.82 million were allocated by the government for *Seri Kenangan* Homes and *Ehsan* Homes respectively.

As for residential care facilities operated by NGOs and private companies, there are 192 facilities registered as Residential Care Centre and supervised by the Ministry of Women Affairs. There are also 17 facilities registered as Nursing Homes governed by the Ministry of Health. Moreover, there are facilities registered as neither type, as well. Type of the elderly in scope and fees of the residential care facilities operated by NGOs and private companies vary according to the facilities. From the perspective of the level of care for the elderly, the standards under the Care Centre Act, which regulates the Residential Care Centres, are less strict than those under the Private Healthcare Facility and Service Act that regulates Nursing Homes. It is therefore considered that Residential Care Centers are designed to provide services for the elderly who are close to 'care for themselves' status, while Nursing Homes are for the elderly in more severe conditions.



Source: Prepared by MURC by on-site hearings and relevant materials

Figure 3-2 Outline of Facilities and Services

[161] News Starit Times, (2012)."Almost 6,000 Residents at Old Folks Homes". Retrieved from http://www.nst.com.my/latest/almost-6-000-residents-at-old-folks-homes-1.157283

1) Facility Services Operated by the Government

a) RSK: Elderly Home [162]

The objectives are to provide care, treatment and shelter to poor older persons for the sake of their well-being and quality of life. The subject elderly are those who are poor but have ability to care for themselves. The governing legislations are the Destitute Persons Act 1997 and the Rules on the Management of Old Folk's Home 1983. There are two types of RSKs, one is the volunteer (voluntary-admission) type and the other is the homeless type. Among the 9 RSKs currently operating in Malaysia, 5 are the voluntary type and 4 are the homeless type.

Those who satisfy the following requirements are admitted to the voluntary type RSK:

- Senior citizens aged 60 and above
- Not suffering from infectious diseases
- Does not have any relatives
- Does not have permanent residence
- Is able to take care of himself/ herself
- Voluntary application by the individuals
- Willing and able to obey the conditions of admission and the relevant Rules on Welfare Home

All applications for admission should be made through the District Social Welfare Officer. Forms should be filled out and sent to the Director of Social Welfare Department for review, comment and recommendation. After that, the application forms will be submitted to the Director General Department of Social Welfare for consideration and approval. New entry is contingent upon vacancies and prescribed conditions.

On the other hand, admission to the homeless type facility is decided by the court. When the district office of the Social Welfare Department finds an aged homeless person, it shelters him/her temporarily and looks for his/her relatives, making the necessary checks for a period of 30 days. If no relative is found within the period, the person is referred to the court and the court gives an order that he/she must be admitted to the homeless type RSK in accordance with the Destitute Persons Act 1997. As permission of the court is necessary for moving the elderly from one facility to another, transfer of a resident is not easy even when the RSK is fully occupied. Under the Destitute Persons Act 1997, the resident can only be accommodated

[162] On-site hearing survey on April 23, 2013 (KPWKM）, On-site hearing survey on April 26, 2013(RSK Cheras), Social Welfare Department, (2012).“Seri Kenangan Home”. Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=93:rumah-seri-kenangan&catid=61:institusi-warga-emas-a-keluarga&Itemid=68

by RSK for a maximum of 3 years. After the 3 years, necessary checks are made again (such as search for relatives) and if no one can be found to support the person, he/she is admitted to RSK for another three years. Incidentally, homeless people younger than 60 are sheltered in Desa Bina Diri, a facility that provides rehabilitation and empowerment programs.

Services and facilities provided are: care and shelter, medical treatment, guidance and counseling, work rehabilitation, physiotherapy services, religious activities, and recreation.

Residents may be discharged if there are people willing to give him/her proper care and shelter, or the resident himself/herself has a source of income to support himself/herself.

Nine RSKs are currently operated, and the maximum capacity is 2,000 people in total. The number of resident elderly was 1,673 in 2004, but increased to 1,695 in 2012. The government has no plans to increase the number of RSKs at present.

Although the RSK is originally designed for the elderly who to care for themselves and RE for the bedridden elderly, RSKs accommodate bedridden ones because REs are fully occupied.

Table 3-2 Number of Seri Kenangan Home(RSK) (Old Folks Homes) and their Residents, 2006-2012

No	Institution	2006		2007		2008		2009		2010		2011		2012	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
1	RSK Bedong	246	129	272	129	251	125	219	125	181	93	189	99	176	100
2	RSK Cheng	118	58	150	79	129	85	129	98	136	106	116	98	96	81
3	RSK Cheras	175	102	133	87	0	0	0	0	44	23	69	47	71	51
4	RSK PengkalanChepa	81	58	86	60	75	53	74	60	76	62	47	49	64	53
5	RSK Johor Bahru	110	63	137	73	152	84	180	116	182	112	149	108	148	105
6	RSK Kangar	113	67	108	65	42	33	39	33	41	34	63	60	53	61
7	RSK Seremban	100	70	101	71	190	111	182	109	149	84	165	91	171	89
8	RSK Taiping	144	78	127	74	124	72	104	67	101	80	101	80	83	69
9	RSK Tanjung Rambutan	156	85	195	93	231	98	299	113	242	122	179	94	152	72
Total		**1,243**	**710**	**1,309**	**731**	**1,194**	**661**	**1,226**	**721**	**1,152**	**716**	**1,078**	**726**	**1,014**	**681**
		1,953		**2,040**		**1,855**		**1,947**		**1,868**		**1,804**		**1,695**	

Source: Social Welfare Department

i. Objectives and Outline of the Services

Objectives are to provide care, treatment and shelter to poor older persons for the sake of their well-being and quality of life. The subject elderly are those who are poor but have the ability to care for themselves. The governing legislation is the Destitute Persons Act 1997 and the Rules on the Management of Old Folk's Home 1983. There are two types of RSKs, one is volunteer (voluntary-admission) type and the other is homeless type. Among the 9 RSKs currently operating in Malaysia, 5 are the voluntary type and 4 are the homeless type.

ii. Conditions and Method to Use the Service

Those who satisfy the following requirements are admitted to the voluntary type RSK:

- Senior citizens aged 60 and above
- Not suffering from infectious diseases
- Does not have any relatives
- Does not have permanent residence
- Is able to take care of himself/ herself
- Voluntary application by the individuals
- Willing and able to obey the conditions of admission and the relevant Rules on Welfare Home.

All applications for admission should be filed through the District Social Welfare Officer. Forms should be filled in and send to the Director of Social Welfare Department for review, comment and recommendation. After that, the application forms will be submitted to the Director General Department of Social Welfare for consideration and approval. New entry is depending on the vacancies and prescribed conditions.

On the other hand, admission to the homeless-type facility is decided by the court. When the district office of the Social Welfare Department finds an aged homeless person, it shelters him/her temporarily, looks for his/her relatives and makes necessary checks for a period of 30 days. If no relative is found within the period, the person is referred to the court and the court gives an order that he/she must be admitted to the homeless type RSK in accordance with the Destitute Persons Act 1997. As permission of the court is necessary for moving the elderly from one facility to another, transfer of resident is not easy, even when the RSK is fully occupied. Under the Destitute Persons Act 1997, the resident can only be accommodated by RSK for 3 years maximum. After the 3 years, necessary checks are made again (such as searching for relatives) and if no one can be found to support the person, he/she is admitted to RSK for another three years. Incidentally, homeless people younger than 60 is sheltered in

Desa Bina Diri, a facility that provides rehabilitation and empowerment programs.

iii. Services Provided and Service Structure

Services and facilities provided are: care and shelter, medical treatment, guidance and counseling, work rehabilitation, physiotherapy services, religious activities and recreation.

Residents may be discharged if there are people willing to give him/her proper care and shelter, or if the resident himself/herself has a source of income to support himself/herself.

iv. Availability of the Services

Nine RSKs are currently operated and the maximum capacity is 2,000 in total. The number of resident elderly was 1,673 in 2004, but it increased to 1,695 in 2012. The government has no plans to increase the number of RSKs at present.

Although the RSK is originally designed for the elderly who have ability to care for themselves and RE for the bedridden elderly, RSKs accommodate bedridden people also because REs are fully occupied.

Table 3-1 Number of Seri Kenangan Home(RSK) (Old Folks Homes) and their Residents, 2006-2012

No	Institution	2006		2007		2008		2009		2010		2011		2012	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
1	RSK Bedong	246	129	272	129	251	125	219	125	181	93	189	99	176	100
2	RSK Cheng	118	58	150	79	129	85	129	98	136	106	116	98	96	81
3	RSK Cheras	175	102	133	87	0	0	0	0	44	23	69	47	71	51
4	RSK PengkalanChepa	81	58	86	60	75	53	74	60	76	62	47	49	64	53
5	RSK Johor Bahru	110	63	137	73	152	84	180	116	182	112	149	108	148	105
6	RSK Kangar	113	67	108	65	42	33	39	33	41	34	63	60	53	61
7	RSK Seremban	100	70	101	71	190	111	182	109	149	84	165	91	171	89
8	RSK Taiping	144	78	127	74	124	72	104	67	101	80	101	80	83	69
9	RSK Tanjung Rambutan	156	85	195	93	231	98	299	113	242	122	179	94	152	72
Total		**1,243**	**710**	**1,309**	**731**	**1,194**	**661**	**1,226**	**721**	**1,152**	**716**	**1,078**	**726**	**1,014**	**681**
		1,953		**2,040**		**1,855**		**1,947**		**1,868**		**1,804**		**1,695**	

Source: Social Welfare Department

b) RE: Home for Chronically ill [163]

i) Objectives and Outline of the Services

The objectives of RE are to provide care, medical treatment, and shelter in a pleasant and comfortable environment to a poor elderly patient who does not require intensive treatment. As a facility for the poor elderly who require care for a chronic disease or in a bedridden status, RE is specialized in terminal care. The governing legislation is the Rules on the Management of Destitute Patient Homes 1978.

i. Conditions and methods for utilization of services

The elderly who are poor and satisfy the following requirements are admitted to the RE:

- Confirmed by a Government Medical Officer as destitute patient
- Not infected by infectious diseases
- Without family/guardian cannot be traced/incapable of caring for the patient
- Without income and mean of support
- Aged 60 years and above

Applications for admission shall be submitted through the District Social Welfare Officer, using the prescribed form and forwarded to the State Social Welfare Department Director for review, comment and recommendation. The application will then be submitted to the Director General Department of Social Welfare Malaysia for consideration and approval.

Residents who are capable of self-support and care may be discharged from the institution at an appropriate time upon confirmation by a Medical Officer, or the willingness of family/guardian or relative to accept him.

ii) Services Provided and Service Structure

Facilities and services provided for the residents as follows:

- Care and Shelter
- Medical Treatment and Health Care
- Guidance and Counselling
- Physiotherapy Services

[163] On-site hearing survey on April 23, 2013 (NACCE）, Social Welfare Department, (2009).“EhsanHome”. Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=94:rumah-ehsan&catid=61:institusi-warga-emas-a-keluarga&Itemid=68

- Religious Guidance and Facilities
- Recreation

The RE accepts elderly who require support for dietary intake.

While the RE is governed by the Ministry of Women Affairs, nurses, physical therapists, and occupational therapist are assigned under the control of the Ministry of Health.

iii) Availability of the Services

There are two REs in Malaysia currently, one is located in KUL. The maximum capacity of each facility is 120 people. Although the number of people accommodated was 128 in 2004, this increased to 217 in 2012.

Table 4.6 Number of Ehsan Home (Severely Ills Elderly Homes) and their Residents, 2006-2012

No	Institution	2006		2007		2008		2009		2010		2011		2012	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
1	Ehsan Home Kuala Kubu Bharu	47	49	46	54	53	55	53	47	61	50	52	55	50	55
2	Ehsan Home Dungun	37	37	46	47	57	47	57	55	60	60	60	60	56	56
Total		**84**	**86**	**92**	**101**	**110**	**102**	**110**	**102**	**121**	**110**	**112**	**115**	**106**	**111**
		170		**193**		**212**		**212**		**231**		**227**		**217**	

Source: Social Welfare Department

c) Service Examples

i) RSK Cheras [164]

RSK Cheras, one of the RSKs serving the elderly that is operated by the government, was opened in 1965. The facility was renovated in 2008 and re-started operations in December 2010. Cheras is a facility that admits people who opt to live in the facility voluntarily.

The maximum capacity of the facility before the renovation was around 200 people, but this was increased to 336 currently. The standard living space is a room with a bath and a toilet for a maximum of 12 people, consisting of two rooms that can accommodate 6 people each. The number of people living in the facility is much smaller than the maximum capacity, because the standards for being admitted to voluntary-admission type facilities are very strict. As the RSKs basically admit people living in that neighborhood, the capacity is filled if there

[164] On-site hearing survey on April 26, 2013 (RSK Cheras)

are many people who are qualified for admission, and if not, there will be empty beds.

There are 75 staff members in the facility, consisting of 5 nurses, 35 caregivers, 1 physical therapist, 1 occupational therapist, 11 social workers, and administrative staff members. Although no doctor is working in the facility, nurses sometimes provide medical treatment in the internal clinic based on the instructions given by the doctor. If a higher level of medical treatment is required, facility employees do not provide any treatment and the doctor comes from the nearby hospital. Medicines are prescribed by the nurses if instructed to do so by the doctor.

RSK Cheras provides rehabilitation and empowerment activities. It provides six meals per day - breakfast, snack, lunch, snack, supper, and snack. Accommodated people are provided with MYR 10 per month with which they can buy sweets, and other things at the shop in the facility. These opportunities are provided so that they are prepared for the basics of daily life, including payment of money. The facility has a big bus which is used by the residents for group outings. Residents get married to another resident sometimes, and in such cases they leave the facility or move to a room for two people (with bath and toilet).

2) Facility Services Operated by Private Companies and NGOs

Residential care facility services operated by NGOs and private companies are categorized into three types – the ones registered as Residential Care Centre supervised by the Ministry of Women Affairs, the ones registered as Nursing Home supervised by the Ministry of Health, and the ones registered as neither. While the Residential Care Centres are governed by the Care Centre Act, the Nursing Homes are governed by the Private Hospital Act.

Incidentally, the RSK and RE, residential care facilities for the elderly operated by the government, are prescribed as “being exempt from regulatory compliance” in the Care Center Act.

a) Residential care centre [165]

Care centres that are subject to the Care Center Act 1993 consist of two types of centres - one is Residential Care Centre and the other is Day Care Centre. The difference between the two is that, while the services are provided for a certain length of time (3 hours or longer per day) and frequency (three days or more per week) at the Day Care Centre, they are provided 24 hours a day at the Residential Care Centre. As the Care Center Act covers not only the facilities for the elderly but also all types of welfare facilities including orphanages, some care centres provide care to the elderly as well as to the children and people with

[165] On-site hearing survey on April 24, 2013 (Legislation and Advocacy Division, Social Welfare Department)

disabilities.

The staff assignment ratio is 1:18 for the independent elderly and 1:4 for the elderly suffering from a chronic disease or bedridden. This is the standard for the number of staff members and it does not mean the actual number of employees always satisfies the 1:4 ratio. Also, the standard is about the number of caregivers, and the number of employees for transportation of the elderly and cooking is not included. As Residential Care Centres admit both the elderly who have ability to care for themselves and those who have chronic illness or are bedridden, the required number of staff members is calculated according to the number of the elderly in each category.

Residential care centres receive visits from authorized officers (District Welfare Officer) every three months for inspection of compliance status with regulatory standards. Any facilities that were found to be not compliant with the standard are advised to make improvements. As the number of facilities operated by the government is limited, the operation licenses are not cancelled easily. The care centres also must submit reports on their financial status and compliance with the standards periodically. Unregistered care centres are not subject to such periodic checks, and the authorities provide inspections only when they receive complaints from users or neighboring communities.

In principle, no medical treatment can be provided at care centres and the facility cannot accept visits from external doctors for medical treatment. However, some medical treatment is provided at both registered and unregistered care centres. For example, retired nurses take care of bedsores based on advice from doctors. Inquiries about the scope of care available at each care centre should be referred to the Ministry of Health.

There are 192 residential care centres for the elderly operated by NGOs and private companies as of March 2013. Among them, 3 were newly opened month of March. If residential care centres for children and disabled people are added, the total number comes to 1,017 facilities.

Care centres (residential care centres and day care centres) must obtain approval of multiple organizations including the Social Welfare Department, the local authorities, the Fire and Rescue Department, the Health Department, and the Land and Survey Department (Sarawak only) before starting operations. Therefore, even if a care centre obtains approval from a certain authority, it cannot be registered until all authorities give their approval. For example, local authorities confirm matters regarding construction, fire prevention measures, and matters concerning the relationship with local communities.

Care centres that were approved as satisfying the regulatory requirements receive financial grants from the central government. This gives motivation for facilities to register. According to the Ministry of Women Affairs, there are about 700 unregistered facilities nationwide that do not satisfy the standards for care centres. These are operated by NGOs and

philanthropic organizations.

The Ministry of Women Affairs sponsors a “1 stop meeting” every quarter with the four organizations that give approval to care centres (local authorities, the Fire and Rescue Department, the Health Department, and the Land and Survey Department) as a place to discuss operation of care centres, both registered and unregistered, at both state and regional levels. Information about unregistered facilities is sometimes provided by the local authorities if they know such activities are in operation in their region. However, there are cases where local authorities do not understand the situation.

b) Nursing Homes [166]

There are old and current standards for nursing homes. The old standard was defined in the Private Hospital Act of 1971. The current standard was enacted in 1998 and executed as the Private Healthcare Facility and Service Act in 2006. While the old standard was defined mainly for construction standards, the current standard is comprehensive and includes management of services, such as meals and recreation, as well as staff. The content is closer to medical organizations than aged care facilities, and medical care is also covered. The service is fee-based and there is no support from the government. There are 17 facilities nationwide that satisfy the current standard. It takes six months to a year to obtain a license from the time of application.

The old standard was abolished in 2006 when the new standard was enacted. However, as the facilities that satisfied the old standard are not forced to adopt the new standard, the reality is that there are facilities run based on two different of standards. Facilities that are established by the Private Healthcare Facility and Service Act are further categorized into mental healthcare and physical facilities. Most of the mental healthcare facilities care for the elderly (including patients with dementia). However there are also mental healthcare facilities for young people and students. Physical facilities mostly care for the elderly. Although a further new standard, the Mental Health Act, was enacted in 2010, the standard is said to be higher than ever and none of the 27 facilities that have applied at this point in time meet the requirements.

c) Service examples

An outline of the following facilities will be described in this section: ECON Medicare Centre and Nursing Home, Eldercare Nursing Home, and My Manor as privately-run facilities mainly for people with high incomes; Asrama Cahaya and Charis Home run by

[166] On-site hearing survey on April 24, 2013 (MOH)

NGOs mainly for those who have no income, and dementia home care centers for elderly people with dementia. Among these facilities only ECON Medicare Centre and Nursing Home (registered nursing home) is registered with the Care Center Act or the Private Healthcare Facility and Service Act.

i) ECON Medicare Centre and Nursing Home [167]

ECON was established in 1987 as a company to develop healthcare and nursing services in Singapore. Their business consists of hospitals, medicare centers/nursing homes, respite care, health wellness centers, home care, emergency transportation services, and retirement villages. Currently, they operate nursing homes at two locations in Malaysia, Kuala Lumpur and Johor Bahru, and they are one of the few registered nursing homes. They plan to open a nursing home in Cheras with 250 beds in the future.

The care that the nursing home management focuses on is for residents to feel like they are at home. Reducing the number of falls and bedsores is on Quality Care Indicator.

The nursing home in Kuala Lumpur exists on three floors of a Chinese maternity hospital. There are 120 beds as of November 2013 and an expansion is planned on another floor to increase the number of beds to 177. Each floor has a recreation area where the users gather to have tea and do other activities.

Allocated staff are doctors, one occupational therapist, three Physical Therapists, staff nurses, and assistant nurses as well as an Experienced Nurse Educator who has worked at nursing homes in England and Scotland, and instructs other nurses.

Based on the Private Healthcare Facility and Service Act, one nurse must always be available for four residents. Also based on the definition of the Private Healthcare Facility and Service Act, 40% of allocated nurses are registered staff nurses. Staff nurses are those who have received special training in nursing.

The roles of nursing staff are defined and categorized into personal care aides that do not require special qualifications, assistant nurses who are new nurses, and registered staff nurses who have received special training. Hospital care assistants learn about risk management, prevention of falls and bedsores, and infectious diseases each month as elderly care training. Staff development is also performed through OJT.

[167] On-site hearing survey on November 15, 2013 (ECON Nursing Home)

The nursing home uses the call bell system and nurses must respond within one minute of receiving a call. Patients also have their position changed every two to three hours to prevent bedsores. Other care is also given, depending on individual needs of patients. Traditional events, such as dumpling festivals, and fashion shows are held for social recreation.

In order to reduce the physical burden of staff, the idea of introducing devices to transport patients heavier than a set weight, following the English standard, is under review. This shows that there are advanced care systems within Malaysia.

Currently there are 130 residents, most of whom are Chinese-Malaysians. Many have left hospitals and entered this nursing facility, and stay lengths vary. Some people enter the facility for rehabilitation purposes and some of them return home once living functions improve. However, there are those who come back to the facility after a few months as they do not have families to look after them.

Among the 130 residents, 70-80% of them use diapers. Many of them are bedridden when they enter the facility, but they are encouraged to get out of bed for meals and rehabilitation a few hours a day. Approximately 10% of the residents are completely bedridden at the moment.

Room types vary from private, groups of five people, and even open dormitories. Cost is decided by a combination of the condition of the resident's health and the room type. Between private rooms and open dormitories, the price difference varies from MYR 3,000 to 4,000 a month. As ECON is a private facility without support from the Malaysian government, the price is comparatively high.

They have adopted the Singaporean standard for the condition of residents' health, separating it into four categories. The Singaporean assessment standard is a system that calculates points on mobility, feeding, toileting, and personal grooming, and nurses generally make an assessment when residents enter the nursing home. In Malaysia, there is no such categorization system at the moment and therefore they have adopted this system to save time estimating service use.

ii) Eldercare Nursing Home [168]

[168] On-site hearing survey on April 19, 2013 (Eldercare Nursing Home）, Eldercare, (2013). Retrieved from http://www.eldercaregivers.com.my/home

Eldercare is a home for full-time assisted living residents, offering medically-skilled care. Eldercare is committed to improving and empowering the residents. The services provided are day care services, nursing homes, palliative care, short term care and rehabilitation care. The operation is not registered with either Care Centre Act or the Private Healthcare Facility and Service Act.

Currently ECON is running two facilities with an enrolment limit of 25, and two facilities with an enrolment limit of 60. As they basically provide for-profit services, they do not accept donations. However, one of the facilities with 60 enrolments allocated 20 places as charity and accepts elderly residents who do not have anyone to look after them without charge.

One of the facilities with 25 enrollments is a renovated three-story apartment building with 12 rooms. Four rooms surround the living/dining room, which is close to a unit style apartment. Sizes differ depending on each room, and there are private rooms and shared rooms. There are private rooms with queen size beds and these rooms are used by couples. While there is no elevator or fence, the staff encourages the residents to gather on the 1st floor and exercise every morning, and helps them move to the first floor when necessary. As an independent facility standard, the area per person is designated at 227 square feet of the entire area of the facility. This standard differs from that of the government.

The current facility is run in a rented building and it would be impossible to operate the business unless the local authorities gave a license to either build a building or rent a building. As many issues, such as fire, are pointed out by the local government, even these licensed nursing homes sometimes have to close after problematic issues come to light. It is particularly important to communicate with neighbors. These nursing homes are as careful as possible of the neighbors, as the local government may order them to close the facility when there is opposition or complaints raised from neighbors.

ECON has an independent personnel allocation standard, and the basic standard is 1:4. At night, one staff member is allocated to each facility and there are several staff members that take care of facilities completely in order for these staff members to have a break. Doctors visit once a week on a temporary basis. There are no specific collaborating medical organizations, however they use the neighboring public hospital for emergencies. Three nurses, eight care workers and one physical therapist are allocated for every 25 residents for rehabilitation and activities.

Most of the staff is young, somewhere between 19 to 26 years old, and the longest serving

staff member has worked for about four years. It is a challenge for them to secure human resources for high quality services. They created their personnel development manual independently with reference to care manuals from Canada, the Philippines, and Australia. The personnel development program that MAKPEM runs is to educate nursing staff about nursing care. However, ECON aims to make a wide range of young people in the region, including unqualified persons.

Some facilities have many bedridden residents while others have more residents with mild disabilities. Even though some residents are bedridden when they enter the facility, the staff are aggressively trying to improve the ADL and some residents are able to walk after entering the facility.

The manager has worked at nursing facilities in England for 12 years and the current standard for business operations is based on those experiences. A special feature of the Eldercare nursing and day care centre is that licensed professional staff and doctors visit every resident to design care plans tailored to the needs of individual residents. At each facility, the ADL assessment, daily vital records, urination and defecation status, medication management (colours, shapes, and purposes), medical history, previous job, and emergency contacts of the residents in each location are recorded. Together with these individual files, the residents are transferred to a neighbouring hospital in the case of an emergency.

The Eldercare Nursing home package including the following:

- 24 hour care, assistance and nursing
- Health record encompassing BP, temperature, HGT etc.
- 6 meals per day
- Weekly doctor's visits
- Reflexology
- Massage
- Physiotherapy in fully air-conditioned rooms
- PAY TV
- Laundry

Meals are an important part of maintaining both physical and mental condition of residents. As the elderly cannot eat enough at a single meal, meals are provided six times a day and nutritional balance is carefully considered. Cooking is not done within the facility, due to the risk of fire and sanitation issues, and the central kitchen cooks and distributes all six meals. Three cooks prepare meals for 190 people including the staff. There is also a driver hired separately to deliver the meals. They handle Halal meals as well (additional fees apply).

Eldercare also provides various programs and activities for senior citizens, especially for those who are still healthy. Some of the activities are recreational, musical entertainment and singing activities, mental stimulation games such as bingo, stretching or other gentle exercises, group discussion and local outings.

The monthly fees are MYR 2,000 for mobile patients, assistance with ADLS, and MYR 2,350 for bed-ridden patients. Furthermore, when requests from residents' families are excessive, bedridden fees may be applied. For couples use, the monthly fee is MYR 3,600, and the use of a private room for a single person is MYR 2,650 per month. The fees include most necessary daily items, such as housing expenses, food, and care costs. Additional charges are required for shampoo, medical items, diapers, and others. Additional charges are required for following services:

- Adult diapers (Normal User) MYR 300 per month
- Adult diapers (Heavy User) MYR 350 per month
- Underpads as needed
- Insertion of ryles tube MYR 60
- Insertion of urine catheter MYR 40
- Minor occasional dressing Free
- Daily dressing service charge MYR 10 to MYR 20 depending on intensity
- Suctioning procedure MYR 30 per time
- Prescription medicine As per pharmacy rates
- Transport Charges to/from Hospital in Petaling Jaya/Kuala Lumpur:
- From our centre to and/or from Hospital Kuala Lumpur MYR 100
- From our centre to and/or from University Malaya Medical Centre MYR 100
- From our centre to and/or from University Kebangsaan Malaysia Medical Centre MYR 100
- From centre to and/or from Klang Hospital MYR 120

ECON plans to add about four more facilities in the next few years. They also plan to have meetings and discussions with different facilities, and are urging 32 facilities in KUL and Petaling Jaya to attend the meetings. There are approximately 57 public and private facilities in KUL. Additionally there are 95 facilities in Johor Bahru that are expected to be used by Singaporeans.

iii) My Manor [169]

My Manor is a private luxury residential home for elderly. It is located in a spacious bungalow with landscape gardens and situated in the heart of Petaling Jaya, Selangor.

My Manor provides long-term care service for the elderly who need more assistance than is available at home, but who do not require the heavy medical and nursing care provided by a nursing home.

My Manor care program is a combination of a healthy diet, exercise, mental stimulation and social interaction. Each resident is assessed by a doctor who, in consultation with his or her family and My Manor personnel, prepare an individual care program. This program is updated every six months or earlier, if required, to ensure that the resident receives the appropriate care as his/her condition changes.

The facilities in My Manor include an office, a large living and dining area, modern fully fitted kitchen, gym room, five bathrooms, a dressing room, outdoor covered patio, a grotto and a koi pond.

My Manor provides the following services to its residents:

- Individual care programmes designed in consultation with a doctor, nutritionist, and family members.
- Monitoring and adjusting care programmes to meet the changing needs of residents. Care assistance programmes are reassessed every six months or earlier if the need arises.
- Personal care services (help with eating, bathing, dressing etc.)
- 24-hour hands-on individual care, assistance and supervision which allows residents to feel at ease and more confident.
- 3 nutritious meals per day. Choice always available.
- Hot and cold drinks and snacks at all times.
- A personal laundry and housekeeping service.
- Medication management.
- Transportation services to doctors/dentist/hospital appointments, religious services etc, within the local area up to three visits in a month.
- A carer to accompany our residents at all times when outside the home, unless visiting friends or relatives.
- Basic Pay TV package, TV and DVD player in each room.
- Basic toiletries, including shampoo, conditioner, soap, toothpaste and body lotion suitable for the elderly.
- Whilst smoking is not allowed within the home a smoking area is provided at the covered patio area.

[169] My Manor, (2013). Retrieved from http://www.mymanor.com.my/

- An internet station for the use of the residents.
- An exercise facility designed for seniors.

The monthly charges for mobile elderly is MYR 5,500 per month. The monthly fee for bed-ridden residents is more than MYR 5,500 per month.

The monthly fee is inclusive of services listed below:

- Full board and lodging.
- Hot and cold drinks and snacks.
- Monitoring and adjusting of care programmes
- 24-hr supervision
- Personal care services (help with eating, bathing, dressing etc.)
- Personal laundry and housekeeping service.
- Medication management programme.
- Transportation for shopping, social outings, doctor/dentist/hospital appointments, religious services and hairdressers during weekdays within the local area.
- Caregiver to accompany resident when off the premises unless visiting family/friends.
- Basic Pay TV package for each room.
- Basic toiletries: shampoo, conditioner, toothpaste, body lotion.
- Email address.
- Use of all facilities within the premises.

The monthly fees do not include doctor, dentist, or hospital charges, ambulance for emergency hospital admittance, diapers, emergency doctor call out, physiotherapy, reflexology, acupuncture or similar services, cost of prescription and over-the-counter medicine, vitamins or health supplements and alcohol. These additional services are billed separately each month at cost.

iv) Asrama Cahaya [170]

Asrama Cahaya is a facility for elderly people with disorders. Originally, the facility was for orphaned children. The facility was opened 160 years ago and two facilities were merged in 1973. The number of residents is 33; the youngest is 56 while the oldest is 88, and the average age is about 66. As there is a shortage of staff, they do not plan to increase the number of residents in the future.

Their services include providing meals, exercise, and workshops. It also includes handcrafts at the handicraft center and asks the resident to do their own laundry if they can. The facility

[170] On-site hearing survey on April 22, 2013 (Asrama Cahaya）

asks the residents to take care of themselves as much as possible and they also encourage social participation by having workshops and selling handcraft products. Through this social participation, this helps residents with self-affirmation and contribution to society. Those who are not capable of doing these activities receive therapy from volunteers, play games, and take walks; some of the volunteers are from the Japan Club.

They do not depend on the government for income, but obtain small amount of financial grants from the Social Welfare Department. The annual amount of financial grants is MYR 50,000, amounting to MYR 4 per person per day. The financial grants from the Social Welfare Department have specific conditions on 1) the number of residents, and 2) the organization has to be an NGO. Public facilities receive more in financial grants. As PWDs can receive medical treatment free-of-charge at public hospitals with OK U cards, it is possible to reduce medical costs (however, they have to pay some amount for medication and hospitalization). Other than financial grants, they obtain donations from companies and religious organizations, and earn cash by selling second hand products. In recent years, companies are interested in donations as part of their CSR.

This facility is controlled by the Social Welfare Department, as a handicapped home. Although there are restrictions and guidelines from the government for facility safety and reporting to the Social Welfare Department, there are also guidelines created independently by the facility itself.

As this facility is not located in a residential area, no complaints are received from nearby residents. However, welfare institutions, including senior citizen institutions, child institutions, and PWD institutions, are known to cause trouble.

v) Charis Home [171]

Charis Home is a home for the aged and home for children. Charis Home is a welfare organization registered with the Registrar of Society (ROS) of Malaysia since 1993. It is a non-profit Christian-based organization, founded in 1988 by Reverend Teo How Ken as a home to serve the old and the aged. The community social services have since been extended to include the Children Home, the Very Strong Old People's Club that organizes activities for senior citizens and the House of Bread, a skills training school for youths. Since its inception more than 20 years ago, Charis Home has been offering social services that provide spiritual guidance, shelter, education and healthy community activities. [172]

[171] Charis Home, (2013). Retrieved from http://www.rumahcharis.org.my/index.asp
[172] Rumah Charis, (2013). Retrieved from http://www.rumahcharis.org.my/rc_intro.asp

Charis Home provides shelter, support and medical care to destitute old folks. Currently, Charis Home has two homes serving the aged; one in Puchong, and one in Penang. Through the establishment of a senior's home, the destitute and homeless can have a place to call home, where they are able to enjoy a better quality of life.

The objectives are:

- To provide shelter for the destitute, especially the elderly.
- To provide spiritual guidance and counselling services.
- To provide medical care for aging seniors in the home.
- To make arrangements to reunite seniors with family and relatives.
- To make arrangements for the funeral service of the seniors of the home.

They plan to add another large-scale nursing home in 2014 in Penang to accept 150 people.

The residents at this facility exercise, go for walks, read and listen to the Bible, and go outside every day. There are 18 residents in KUL and 32 in Penang. Conditions of residence stipulate that one must be older than 60, have no family, and be healthy. Residence is free. Each elderly person receives a pension of MYR 300 and, in the case of PWDs, they receive the same amount through PWD registration. As it is easier to be registered as a PWD in Penang than in KUL, the PWD of this facility are registered in Penang (residence in KL is not an issue). With the PWD card, public transport is half price.

All the residents in KUL are Chinese-Malaysians. While there are Malay and Indian-Malaysian residents in Penang, most residents are Chinese. There are seven staff members in KUL and 10 in Penang, and orphanage graduates also work there.

Most business operation costs are covered by donations from the private sector. The annual running cost of the center is approximately MYR 20,000. As they are a religious organization, they do not receive financial grants from the government. However, in 2012, they fixed the roof of the KUL center using financial grants received from the government. They have received continuous support from Japanese Christian organizations over the past 25 years of operation, and they have received invitations for nursing care training in Japan. The facility in Penang received Japanese grass-roots grant aid in 1997 (MYR 7,000) and this was used to extend the facility's kitchen. They have not received financial support from the parent church.

People from the Philippines and Indonesia are employed as care workers. Due to the low wage for care workers, it is a challenge to secure staff. Foreign care workers are hired via agencies for around MYR 1,000 per month. In Malaysia, there are no care training courses,

standardized textbooks, or guidelines for nurses. The demand for nursing care is increasing, and it is a challenge for society as to how they should care for elderly people who need constant care.

Charis Home also established a community project, the V.S.O.P Club which stands for Very Strong Old People Club. The aim of the club is to provide an avenue where senior citizens from all walks of life can gather and spend some time in games, interaction, learning new skills amidst a healthy and conducive environment.

The club members are mostly 60 years old and up, as well as some those below this age and retired or having met the club requirements. [173]

The concept of the club revolves around the 5 E's:

- Exists: to affirm the senior citizens' status and dignity through independent participation in activities.
- Enable: the senior citizens to have a stable lifestyle through proper use of their time.
- Encourage: the public to care and love the senior citizens through organized interactive social activities.
- Enlarge: the potential abilities of the senior citizens to be useful citizens through learning new skills.
- Equip: the senior citizens' club to be a place for relaxation and a learning centre with professional services.

Hence, Charis Home provides various activities and opportunities for senior citizens to use their time in a healthy and interactive atmosphere where they can meet friends and make new friends in the process, enhance their self-image and confidence, sharing experiences and knowledge, and have opportunity to hear and be heard as they share their favourite topics in group discussions.

vi) Dementia Homecare Centre (DHCSB) [174]

Many caregivers have requested residential care for their loved ones as they sometimes need to travel or cannot provide care due to work commitments, or other reasons. DHC, an affiliate of ADFM has operated a Dementia Homecare Centre (DHC) at Telok Panglima Garang, Kuala Langat since April 2011 to provide long-term care.

The Dementia Homecare Centre (DHC) provides:

- Peaceful, serene surroundings for loved ones in the midst of greenery and fresh air. It is near Carey Island and not far from the sea, hence the breezy atmosphere.

[173] Charis Home, (2013)."VSOP Club". Retrieved from http://www.rumahcharis.org.my/rc_vsop.asp
[174] Alzheimer's Disease Foundation Malaysia, (2013). Retrieved from http://www.adfm.org.my/Home/foundation、ADFM, (2011). "ADFM Newsletter Sharing"

- Live in non-crowded space as we intend to keep our numbers low and manageable despite the large and spacious premise and compound. There are only 23 beds and just over half are occupied at present.
- Daily mind and body stimulating exercises, games and activities will be the menu.
- Care initially provided by a Team of 5 live-in qualified with 3 year Diploma in Nursing and trained nurses, led by an experienced Senior Nurse Manager. The nursing/carer staff will grow with increasing clients.
- DHC requires that family members keep in close touch with their loved ones and visit them regularly.
- Bi-monthly voluntary visits by Consultant Psychiatrist, Dr John Tan Jin Teong, ex UMMC, now in private practice to advise on cleanliness, hygiene and Dementia care.

The fees for the admission and services are as below:

1. Dormitory: Large rooms with 6 and 7 beds for male and female clients with 2 ceiling fans and 2 attached bathrooms per large room; the independent client fee is MYR 2,100 per month.

2. Triple occupancy: Room (15'6" x 9'6") with ceiling fan and bathroom attached for the independent client costs MYR 2,300 per month. The fee for a room with air-conditioner is MYR 2,400 per month.

3. An additional fee for wheel chair bound client of MYR 400 is charged per month, whereas bed-ridden clients are charged MYR 800 per month. Medication and pampers are on own account.

3) Hospitals for the Elderly (Recovery Phase) [175]

There is a geriatric unit in the Hospital Kuala Lumpur (national hospital) and it belongs to the Department of Medicine. There are 20 beds in the geriatric unit and usually 15 beds in a room. Three doctors, 20 nurses, seven nursing assistants, one medical officer, and two health officers belong to the geriatric unit.

There are patients who moved to General Medicine from within the same hospital and they receive rehabilitation for several weeks before leaving the hospital. Most of the patients who move to the geriatric unit have had strokes or pneumonia caused by lifestyle-related diseases. They usually stay in the hospital for a period of three to four weeks. As there is not enough staff or space, the hospital cannot let them stay longer than that. In reality, patients who need to stay in the hospital a bit longer are transferred to other facilities, such as nursing homes and residential care centers. As there are only 17 facilities registered as nursing homes, some

[175] On-site hearing survey on April 25, 2013 (Geriatric Unit, Hospital Kuala Lumpur)

people move to non-registered nursing homes and care centers. Medical social workers are consulted as to which facilities patients move to.

In Malaysia, two ministries, the Ministry of Health and the Ministry of Education, control hospitals. Public hospitals, such as Hospital Kuala Lumpur, are controlled by the Hospital Health Division of the Ministry of Health, and teaching hospitals are controlled by the Ministry of Education.

One medical social worker, who is in charge of the geriatric unit, is hired by the Ministry of Health and works at the hospital under their control. Their role is limited within the hospital and they assist the elderly and single mothers within the hospital. After patients leave the hospital, social workers belonging to the Ministry of Women Affairs take over this role. There are hospitals that do not have medical social workers.

4) Discussion for the comprehensive definition of facility services

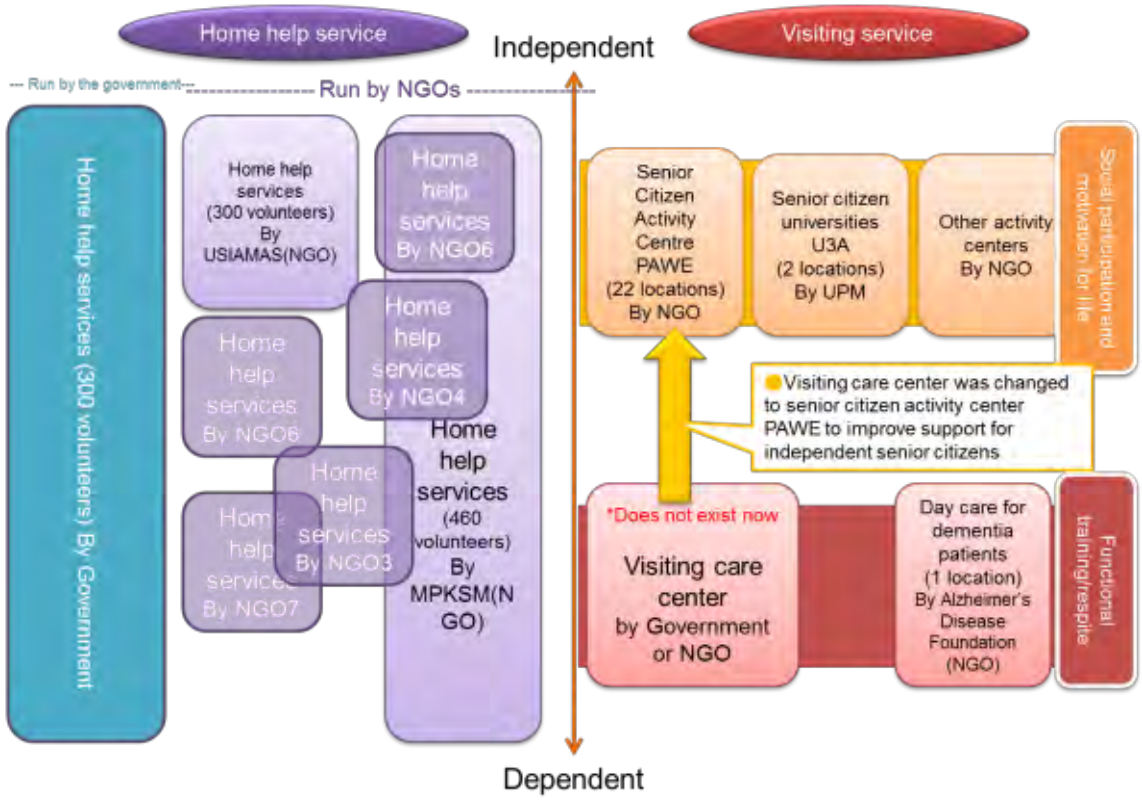
Facility services for the elderly are separately defined; residential care centers by the Care Center Act and nursing homes by the Private Healthcare Facility and Service Act. There is a huge difference between the service standard in the Private Healthcare Facility and Service Act, which is as strict as hospitals, and the Care Center Act as its target is the mildly disabled. Therefore, in reality it is possible that unregistered facilities might be offering facility services for mild PWDs, and this makes it difficult to monitor the quality of services and ensure user rights. The Ministry of Health is currently aiming to create a comprehensive definition of facility services for the elderly. If this is achieved, it will be possible to secure the quality of facility services. Furthermore, if financial support, such as grants, are secured, the range of services may be expanded.

Furthermore, the medical care standards at nursing homes are as strict as hospitals, and therefore it is assumed that medical care is provided under the instruction of staff nurses without any major problems. On the other hand, it is said that there are Residential Care Centers that provide some medical care, although in principle they are not allowed to do so. When Residential Care Centers provide medical care, they are supposed to receive permission from the Ministry of Health first. However, it is unlikely that they are properly managed at all times. It is also very possible that unregistered nursing homes are providing medical care without regulation from the government. If a comprehensive definition for facility services were created, it would be possible to regulate this medical care under a set standard. Necessary and appropriate human resources for medical care could be secured from financial grants for facilities that satisfy the requirements.

(2) In-Home Services

In-home services for the elderly are home care services, visiting type services, purchase support for synthetic tools, and Elderly Caring Unit (UPWE). There are also activities for families who are taking care of patients with dementia to support caregivers.

The diagram below shows the outline of home help and visiting services, and social participation and motivation for life support services (social participation and motivation for life are described as visiting services). Home help services are operated by the government and NGOs, and visiting services by NGOs and universities. The Social Welfare Department proposes guidelines, and instructs and supervises the home visiting services and the Senior Citizen Activity Centre/Pusat Aktiviti Warga Emas (PAWE). The Day Care Centre used to provide services for people who needed support and care, but it no longer exists because it was absorbed by the PAWE in order to expand support services for independent elderly people.



Source: MURC created by various hearings and documents

Figure 3-3 Outline of home help and visiting services, and social participation and motivation for life support services

Some NGOs are receiving financial grants from the government to develop home care services, UPWE, and PAWE. The following table shows financial grants paid by the government to NGOs.

Figure 3-4 Financial grants for NGOs (2010)

States and directly governed cities	Number of NGOs that receive financial grants	Total (MYR)
MANAGEMENT GRANT	3	2,099,568
PERLIS	-	-
KEDAH	-	-
PULAU PINANG	3	701,384
PERAK	2	188,048
SELANGOR	3	245,280
KUALA LUMPUR	2	62,780
NEGERI SEMBILAN	-	-
MELAKA	1	58,400
JOHOR	1	85,848
PAHANG	1	32,120
TERENGGANU	1	122,640
KELANTAN	1	2,000
SABAH	-	-
SARAWAK	1	53,144
TOTAL	**19**	**3,651,212**

Source: Documents supplied by the KPWPM

1) Home help services

a) Home Help Service [176]

i. Purpose and outline of services

Home Help Service was a pilot project under the GTP 1.0, and will be further expanded under the GTP 2.0. Its main objective is to provide support to individuals who are unable to adequately care for themselves at home. Government grants and donations fund helpers/NGOs to assist these vulnerable individuals with daily activities, so they can remain independent in their own homes rather than be forced into a nursing home.

Objectives of home help services are as follows:

- Provide care facilities to senior citizens who live alone at home.
- Provide direct services to the target group.
- Increase collaboration between voluntary bodies to help the elderly who cannot afford care and are unable to manage their old-age life.

[176] On-site hearing survey on November 13, 2013 (Community Development, Social Welfare Department, Negri Sembilan State）, On-site hearing survey on November 14, 2013 (Community Development, Social Welfare Department, Melaka State）, Social Welfare Department, (2013).“Home Help Service”. Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=750%3Aprogram-khidmat-bantu-di-rumah-home-help&catid=38%3Awarga-tua&Itemid=73&lang=en、PEMANDU, (2011).“Raising Living Standards of Low Income Households”. Retrieved from http://www.pemandu.gov.my/gtp/upload/GTP2_ENG_Cp7.pdf

In the midst of population aging, the Malaysian government utilizes Welfare Volunteers who are registered with the Social Welfare Department to provide services, in addition to the services provided by NGOs to expand home help services. When there are human resource shortages in places where registered volunteers of the Social Welfare Department provide services, local NGOs collaborate sometimes to provide services. Currently, there are seven NGOs that provide home help services.

Home help services are provided by volunteers who are registered with the Social Welfare Department and each NGO. There are approximately 300 volunteers registered with the Social Welfare Department at the moment. The department is flexibly distributing the volunteers not only for home help services, but also for Social Services, such as sports, as necessary.

Each NGO that operates home help services receives MYR 33,000 in financial grants annually from the Social Welfare Department, which is used to provide home help services as well as other services. It is left up to each NGO whether they pay the volunteers for home help services, and there is no set standard from the Social Welfare Department (USIAMAS and CWC pay MYR 100 per month to volunteers who meet the conditions set by each organization, as described later).
The Social Welfare Department Community Development staff in each state instructs and supervises NGOs that are providing home help services. Each NGO is supposed to allocate one program coordinator to each of the nation, state, and local level.

The Social Welfare Department plans to convene the Meeting of Programme Coordination and Advisory Committee twice a year, and the Meeting of Home Help Services Programme Implementation Committee three times a year with NGOs that provide home help services. The plan is for each NGO, the Ministry of Health, the State District Officer of Social Welfare Department, and specialists from third party organizations to attend the meetings.

Table 3-2 NGOs that provide home help services

	NGO	Service areas	Number of parliamentarians
1	BULAN SABIT MERAH MALAYSIA	P.PINANG	13
		PERAK	24
		W.P K. LUMPUR	12
2	MAJLIS PUSAT KEBAJIKAN SEMALAYSIA	PERLIS	3
		KEDAH	15
		MELAKA	6
		TERENGGANU	8
		KELANTAN	14
3	PERSATUAN KEBAJIKAN USIAMAS MALAYSIA	SELANGOR	22
		N. SEMBILAN	8
4	GERONTOLOGI MALAYSIA	PAHANG	14
		JOHOR	26
5	NGO`S i. MAJLIS KEBAJIKAN SOSIAL SARAWAK ii. SOCIETY KUCHING URBAN POOR	SARAWAK	31
6	PERSATUAN SUKARELAWAN SABAH	SABAH	25
7	JKMNW.P LABUAN	LABUAN	1
TOTAL			**222**

Source: Outline for the Social Welfare Department home help services

ii. Service conditions of use and how to use them

People who can use home help services are elderly and disabled people left at home alone when their families are not at home. In reality, the targets for the service differ between the Social Welfare Department and each NGO. The Social Welfare Department targets the elderly, PWDs, and bedridden people. Some NGOs, such as USIAMAS, only target the elderly, while others target the elderly, PWDs, and bedridden people.

No specific conditions of use have been determined and someone who wants to use the service just has to call the Social Welfare Department district office to be able to use the service.

iii. Services provided and provision system

The Social Welfare Department defines the standard and guidelines for home visiting services.

It describes the concept, purpose, services to be provided, and volunteer conditions.

The content of the services include meals, bathing, nail clipping, communication, recreational activities, cleaning, laundry, banking, bill payment, shopping, physical therapy, counseling, instructions to caregivers, health advice, accompanying users to hospitals, instructions on medication, accompanying users to religious services, and other necessary support.

Visits are at least once a week and the minimum visitation hours are eight hours a month. Besides submitting reports to the Social Welfare Department, volunteers are required to take training and, where necessary, attend conferences and case meetings to share their experiences with other volunteers.

In order to become a volunteer, one has to be over 18, able to read and write Malay, have an interest in serving the elderly and PWDs, be healthy, and have no prior criminal record. The Social Welfare Department has also determined that all staff and volunteers involved with home care services need to attend training run by the Malaysian Social Institute and NGOs. The content of training includes issues concerning home care services, care for the elderly and PWDs, counseling, and other matters concerning home care services.

iv. Current situation of service provision

Currently, there are 1,582 elderly people using the services. A ratio of one volunteer to five elderly people is guaranteed, and 443 volunteers are actively working at the moment. The target under this program is to provide home help services for 2,500 people/elderly by 2015.

Table 3-3 Targets for home care services

	2013	2014	2015
Key Outcome	1,500 elderly to receive help daily	2,000 elderly to receive help daily	2,500 elderly to receive help daily
NGOs	300 volunteers	400 volunteers	500 volunteers

Source: Social Welfare Department website/Raising Living Standards of Low Income Households

The guidelines determined by the Social Welfare Department aim to allocate at least 10 volunteers per one parliamentarian and have one volunteer for two to four users. If this is achieved, there should be 2,220 volunteers secured as shown in the following table, and it would be possible to provide services for 8,880 elderly people and PWDs.

Table 3-4 Number of volunteers and users when each NGO meets the guidelines

	NGO	Service areas	Number of parliamentarians	Number of volunteers and users	
				Volunteers	Users
1	BULAN SABIT MERAH MALAYSIA	P.PINANG	13	130	520
		PERAK	24	240	960
		W.P K. LUMPUR	12	120	480
2	MAJLIS PUSAT KEBAJIKAN SEMALAYSIA	PERLIS	3	30	120
		KEDAH	15	150	600
		MELAKA	6	60	240
		TERENGGANU	8	80	320
		KELANTAN	14	140	560
3	PERSATUAN KEBAJIKAN USIAMAS MALAYSIA	SELANGOR	22	220	880
		N. SEMBILAN	8	80	320
4	GERONTOLOGI MALAYSIA	PAHANG	14	140	560
		JOHOR	26	260	1,040
5	NGO`S If. MAJLIS KEBAJIKAN SOSIAL SARAWAK ii. SOCIETY KUCHING URBAN POOR	SARAWAK	31	310	1,240
6	PERSATUAN SUKARELAWAN SABAH	SABAH	25	250	1,000
7	JKMNW.P LABUAN	LABUAN	1	10	40
TOTAL			**222**	**2,220**	**8,880**

Source: Outline for the Social Welfare Department home help services

b) Home visit nursing [177]

Currently there is no home visit nursing provided for the elderly. The Ministry of Health and the Public Service Department of Malaysia/Jabatan Perkhidmatan Awam Malaysia (JPA) are discussing public home visit nursing at the moment. Home visit nursing services are already available for women after giving birth and mothers are educated on how to raise their babies.

The Ministry of Health is currently proposing to introduce comprehensive home nursing services, which target women after giving birth, patients after surgery, and the elderly to provide care from doctors, physical therapists, and nurses as a team. Short visits are envisaged and the main purpose is to recognize poor health conditions of local residents at an

[177] On-site hearing survey on April 24, 2013 (Family Health Development Division, Ministry of Health)

early stage. As the target expands beyond women after giving birth, the rule was revised so nurses can conduct post-surgical care, such as handling catheters. These activities are to strengthen the health of communities. However, the service has not been implemented yet.

c) Examples of services

In this section, home visit nursing provided by CWC in Perlis, Kedah, Melaka, Terengganu and Kelantan and USIAMAS in Selangor, N.Sembilan is outlined.

i) Home nursing service operated by CWC (NGO) (Melaka) [178]

Home nursing service operated by CWC in Malaka is not only for the elderly but also for PWDs and the bedridden. For the elderly, CWC provides services for 1) single people, 2) couples without children to care for them and 3) people who are bedridden. For 3) it is not critical if they have families or not, and CWC provides the services including support for families. There is no restriction on use care level, and anyone from independent to bedridden people can use the service. For comparatively young elderly people, CWC provides support for cooking, shopping, and going out. For very old people, CWC physically helps them change their clothes and go to the bathroom.

When there are requests to use the service, the staff of the Social Welfare Department visits the requester and the service will be provided once the need is approved.

One volunteer takes care of two houses. The service is provided one hour at most for each visit every day except for holidays. On the top of regular visits, the users call volunteers and receive services as necessary. If eight hours of service at most is provided a month, MYR 100 is paid to the volunteer. In the Jasin area, there are 12 volunteers at the moment to provide services for 17 houses.

The ratio of volunteers between men and women is 1:1. Besides ex-government staff and housewives, university students are working as volunteers. CWC speaks to schools and students to secure human resources. Usually the volunteers live close to the users so it is possible for them to visit the users if something happens.

[178] On-site hearing survey on November 14, 2013 (Community Development, Social Welfare Department, Melaka State)

ii) Home nursing service operated by USIAMAS (NGO) (N.Sembilan) [179]

Home nursing services provided by USIAMAS in Selangor started as a pilot project and currently they operate in two states, N.Sembilan and Seremban.

In Seremban, USIAMS targets people living by themselves and people who are at home alone during the day (regardless of whether they have children or not), but not people with economic problems, sickness, or PWDs. The ethnic group of the user is not an issue and all the groups, such as Malays, Indian-Malaysians, and Chinese-Malaysians, are accepted.

One simply has to apply to the district office of the Social Welfare Department when wanting to use the service. After applying, the District Office staff visit the person who needs the service to interview them in order to understand their economic and health status, and to estimate what is necessary for the user in regards to economic support, housing, social participation, motivations in life and community support. When the staff finds community support is necessary, the user receives the home nursing service. Sometimes, notifications come from the village headman to the District Office of the Social Welfare Department when there are elderly who need support in the community.

Their services include shopping, banking, payment of utilities bills, replacing light bulbs, transportation to hospitals (transportation by the volunteer's car), cleaning, counseling, and washing hands and feet.

These services are provided by paid volunteers. Their system is not that one user is visited by different volunteers, but rather one volunteer looks after the same user(s). Currently there are approximately 100 volunteers who are registered in Seremban and about 30 of them are actively working. Female volunteers take care of female users and male volunteers male users.

Volunteers who are taking care of more than four users receive MYR 100 a month. Volunteers who support less than four users receive no payment. Even if volunteers support more than four users, the payment is still MYR 100. The number of volunteers depends on their other activities, and as each user lives far apart from each other in farming villages, the number of volunteers is small. However, there tends to be a larger number of volunteers in cities where the users live comparatively close to each other.

[179] On-site hearing survey on November 13, 2013 (Community Development, Social Welfare Department, Negri Sembilan State)

Anyone can become a volunteer by attending a three-day training program jointly held by USIAMAS and CWC. The reality is that most volunteers are retirees or people on pensions that are older than 55. To get new volunteers, volunteers ask people around them to become volunteers, and USIAMAS holds seminars geared toward students.

In addition, there are three trainings a year held by the Social Welfare Department for volunteers. They also hold weekly and monthly meetings for volunteers to share their problems and ideas.

The visiting frequency is once a week (four times a month) and the volunteer stays there for one hour at most per visit. When users need a volunteer, they call and ask the volunteer to come to their place. Volunteers generally live in the users' neighborhood and therefore they can visit the user immediately.

User information is managed by visiting records. The visiting record contains the record of support provided by each volunteer and shows whether users need support for meals, urination and defecation, bathing, shopping, and going out. Each ADL, IADL, and capability, such as vision and hearing, has a user assessment sheet. This record was made to standardize the quality of services provided by each volunteer. This record is collectively managed at USIAMAS headquarters in Kuala Lumpur and each volunteer carries it. The Korean model is used as a reference to provide services. This assessment sheet is also copied from the Korean model.

Elderly people who have little connection with society become depressed if left alone, so the home nursing service is also used as an opportunity for social participation.

Because the care standard of volunteers is basically similar to homemaker services, it is necessary for volunteers to hand their tasks over to other NGOs when the elderly people's health worsens and physical support is required. Depending on economic conditions, volunteers might encourage the elderly to reside in senior citizens homes and sometimes users ask to do so. However, in reality, even if user health worsens, it is not possible for NGOs to stop providing the service. Therefore, volunteers periodically ask users if they intend to keep using the service, and continue to provide the service if they do. Sometimes users might enter the hospital and they might restart using the service for medication support after leaving the hospital. When it is difficult to live alone after leaving the hospital, patients sometimes stay at the volunteer's home for a certain period of time.

The Community Development staff at the Social Welfare Department instruct and supervise

volunteers. They understand the situation from the weekly and monthly meetings and conduct interviews with users if anything concerns them. When users request to change volunteers, the staff gives the user a volunteer who can satisfy their needs.

2) Visiting services

a) Day Care Center [180]

Day care centers are visiting services aimed at increasing the independency of elderly people's lives together with their families in the community. Targeting the elderly who are over 60, day care centers support the elderly mentally, conduct recreational and rehabilitation activities, provide financial assistance, and offer opportunities for the elderly to show their special knowledge and experiences.

Opening hours are from 7:30 to 17:30 every day except for Sundays, holidays, and special community holidays. A user can visit and join in activities anytime during opening hours. Day care centers are controlled by the day care center committee or governmental organizations, and there is always one manager and two assistants on-site.

Day care centers, as well as residential care centers, are facilities that are defined by the Care Center Act (1993), and they are required to be operated continuously for more than three days a week and three hours each time. Similar to residential care centers, some day care centers take care of not only the elderly but also children and PWDs.

There were 17,014 users as of May 2011. However, in order to fulfill support for independent elderly, it was transformed into a Senior Citizens Activity Centre PAWE to be described later in the report and no day care center exists now.

b) Day care for patients with Alzheimer's disease [181]

i. Objectives and outline of service

ADFM operates one daycare location for people with Alzheimer's disease and other forms of dementia, offering brain stimulating activities and respite care.

ii. User eligibility for service and procedures

The centre accepts any person with Alzheimer's disease, regardless of age, provided that they bring a letter of recommendation signed by a hospital doctor. Currently, about 20 people

[180] On-site hearing survey on April 24, 2013 (Legislation and Advocacy Division, Social Welfare Department)
[181] On-site hearing survey on March 31, 2013 (ADFM)

use the centre. Though not restricted by ethnicity, the ethnic Chinese account for 70% of the user base with a heavier representation of women (other ethnic groups are: Indian (10%) and Malay (20%)).

The centre charges 40 MYR per day, and the frequency of two visits per week is the most common pattern of visits.

iii. Services offered and structure of services

Users participate in activities such as "brain gym" and calisthenics designed to stimulate brain activities. Many elderly users suffer from depression combined with Alzheimer's disease, and attention is given to address their special needs. No transportation to and from the centre is provided, and visitors are dropped off and picked up by their family members by car. The centre only accepts users with a mild degree of dementia; the centre cannot reach out to people with severe dementia or those with no access to their own means of transportation.

The centre has five permanent personnel (chairman, nurse, caregiver, and administrative clerk) and temporary staff (cook).

The centre's activities are mostly funded by third-party donations, as the centre does not rely on financial grants from the government. Donations from private companies to NGOs are eligible for tax deduction.

iv. State of service availability

In Malaysia, public awareness of Alzheimer's disease still remains low, and doctors specializing in Alzheimer's disease are limited in number and concentrated in urban areas. These factors impair early detection of the disease, even with hospital examinations, and often result in further progress in dementia stage. Day care facilities for Alzheimer's patients similar to the one operated by ADFM are available only in the vicinities of Kuala Lumpur, and in provincial areas patients are cared for primarily by their own family members. For this reason, ADFM's long-term goals include provision of assistance to facilitate the launch, in all states, of daycare centres that support local communities.

3) Synthetic tools or support tool [182]

- Helping disabled people who cannot afford to buy equipment such as prosthetic limbs, artificial hands, callipers, axillary or underarm crutches, wheelchairs, hearing aids, special glasses, special shoes and other equipment recommended by the doctor.
- Enable the disabled to enhance their abilities, and live their life without depend on

[182] Social Welfare Department, (2012)."Senior Citizens Services". Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=65%3Awarga-tua&catid=38%3Awarga-tua&Itemid=159&lang=ms

others completely.

4) UPWE: Elderly Caring Unit [183]

The Elderly Caring Unit (UPWE) is a partnership between the Social Welfare Department (JKM) and Central Welfare Council Peninsular Malaysia (MPKSM). The UPWE program's objective is to provide transport facilities to senior citizens seeking treatment or medical examination at the hospital or clinic. This program is implemented by MPKSM and monitored by the JKM officer. Senior citizens who require the services will be identified by the MPKSM in collaboration with the District Social Welfare Officer.

UPWE's objectives have been set forth as follows:

・Providing transportation to the elderly in need of treatment.
・Reducing the cost shouldered by the elderly for their transportation.
・Making public facilities more accessible.
・Providing an environment where the elderly with physical and mental challenges have access to treatment.

Target groups are senior citizens who live alone or are from low income household.

5) Assistance to family caregivers [184]

Assistance to family caregivers is not widely available currently, but there is a growing trend to extend assistance to family caregivers of dementia patients.

In Malaysia, public awareness of Alzheimer's disease and other forms of dementia remains low, and the mechanism to support and train caregivers is far from adequate at this point. With the limited number of daycare centres similar to the one operated by ADFM, as mentioned earlier, family members must assume the primary role in providing care for dementia patients, especially in rural areas.

Given this environment, ADFM aims to set up daycare centres in all states, while parallel efforts are made to place greater emphasis on respite service. This service allows caregivers to take a rest or run errands they cannot perform otherwise. The daycare centre has embarked on activities designed to support family caregivers. They include training to improve caregiving skills, monthly meetings and discussion sessions. The meetings are translated into a forum of exchange, where participants can exchange information and ideas with their peers. Once every few years, ADFM stages a National Caregiver Seminar on an overnight basis,

[183] Additions and modifications were made to JICA (2012), Malaysia," in JICA, Data Collection Survey on Social Security Sector in Asia Final Report: Country Report, pp35.
[184] Additions were made to On-site hearing survey on March 31, 2013 (ADFM)

which serves as a retreat and a forum of exchange where caregivers can interact with each other in a relaxing atmosphere.

Home help services run by JKMM and NGOs are available to the elderly and the disabled living with their families, in addition to those living alone. One of their service objectives is to support family caregivers so that they can continue caring for their loved ones. The growing importance of respite care is also evident.

(3) Fostering and securing of caregivers [185]

There are three classes of qualified care providers for the elderly in Malaysia, in line with its National Occupational Service Standard, set forth by MOHR. MKPEM also provides standards for training for elderly care and specific management standards, both of which have been designed by MAKPEM based on the information furnished by JKMM and MOH/KKM. The training is open only to the employees of elderly care facilities and nursing homes, as well as to trainers.

MAKPEM offers its training courses in coordination with Open University. A total of 20 training courses are offered by MAKPEM and Open University, with each offering 10 courses. Participants must begin with a training course offered by MAKPEM. After completing three out of 16 courses there, participants are admitted to Open University. A certificate is issued to the participant at the completion of courses at Open University. Because participants hold regular jobs as NGO employees or workers, classes are held on an intensive basis. Intensive lectures are held in Kuala Lumpur at the pace of one session per month, with each session offering five days of training. The entire duration is 15 to 16 months. The training courses by MKPEM and by Open University were initiated in 1999 and 2007, respectively. Open University can accept up to 30 participants each year, and as of December 2012, 120 people had participated in the program on a cumulative basis, and 112 of them completed the program. MAKPEM offered a total of 334 courses taken by 9,631 people, as of December 2012.

In the absence of certification or license as vocational caregiving specialists, facility services depends largely on nurses as the source of their staff, while home care services are primarily provided by volunteers. To illustrate this, registered nursing homes provide training to nurses to prime them for elderly care and take them in as registered staff nurses. Under the supervision of the registered staff nurses, assistant nurses provide nursing care while unlicensed personal care aides provide personal care for the residents. Home help service is delivered by volunteers who have completed a certain level of training.

[185] On-site hearing survey on April 18, 2013 (MAKPEM)

(4) Support for social participation and for finding purpose in life

To assist senior citizens participate in the community and find a purpose in life, NGOs and universities operate centres that offer opportunities for independent senior citizens to participate in activities. Activity centres run by NGOs include projects that operate as PAWEs (Senior Citizen Activity Centres/Pusat Aktiviti Warga Emas), which are eligible for financial grants from the Ministry of Women Affairs, as well as NGO projects without financial help from the government. For instance, NACSCOM's day centres, which will be discussed below, are examples of activity centres that do not rely on financial grants from the government.

It should be noted that PAWEs are former day care centres that focused primarily on care and rehabilitation. They were converted into PAWEs to cater to independent senior citizens' needs with an emphasis on offering recreational activities and serving as a forum where the elderly can develop a sense of belonging.

1) Senior Citizen Activity Centre/Pusat Aktiviti Warga Emas: PAWE) [186]

i. Objectives and outline of service

PAWEs are day care facilities for the elderly living alone or the elderly who are left behind in their homes while their family members are off to work. They offer opportunities to participate in activities on a regular basis. Their activities and programs are designed to help the elderly maintain functionality, interact with others, participate in community activities, acquire new skills and knowledge and engage in community volunteer actions. They offer services aimed at assisting members stay healthy and active so that members can contribute to the community with their skills and experiences. Since their launch in 2003, PAWEs, which are former day care centres, have sprouted up at 22 locations. PAWEs are governed by the Care Centre Act.

ii. User eligibility for service and procedures

Target users are healthy senior citizens aged 56 and over who are able to take care of themselves without assistance. Each PAWE provides service to about 30 senior citizens. Users can participate in any of the activities and programs of their choice.

Users must register first to use a PAWE. Some PAWEs charge a sign-up fee, but many require no usage charge after sign-up as a measure to encourage frequent visits to the facilities. JKMM could consider and allow fee-based services, if, in its judgment, service fee

[186] Seminar on the Caring of Elderly Group- the Development of Elderly Care System and its Financing Mechanism, On-site hearing survey on November 13, 2013 (Activity Center PAWE in N.Sembilan), On-site hearing survey on November 14, 2013 (Activity Center PAWE in Melaka), On-site hearing survey on November 15, 2013 (Activity Center PAWE in Selangor)

would contribute to more stable operations of PAWEs and PAWEs have become an important part of the local communities. JKMM also states that the fee, if imposed, must be set at a level where no profit is made by operators.

When registering, the prospective user needs to fill out a prescribed form with information including health status and information about his/her family and relatives, in addition to his/her name, address and other basic personal information in order to be officially listed in the Registration Book. Once registered, the user is entitled to use the facilities as long as they like, as there is no maximum term of membership (i.e. no system of “graduation” in place). Each PAWE maintains an attendance book to monitor attendance, and activities taken by members and dates thereof are recorded. If a regular user does not show up for a prolonged period, some PAWEs go so far as to check the cause of his or her absence by making inquiries to the user’s neighbors.

iii. Services offered and structure of services

JKMM has established guidelines for PAWEs, and all PAWEs are required to comply with the Guidelines, which address business hours, target users, services delivered (no detailed rules for activities or programs), user records, management structure, staff allocation, wages, financial grants, and financial control.

PAWEs are open daily except Sundays and holidays from 7:30 a.m. to 5:30 p.m. (base hours), which may be adjusted to better accommodate the operating environment and needs of each community. Activities and programs offered may include recreation, sports, wellness enhancement, therapies, rehabilitation, religious activities, training courses and volunteer services, among others, and each PAWE is free to plan and deliver activities and programs to suit its user’s needs. PAWEs make sure to tailor their activities to suit local residents. Chinese language and Tai Chi classes are offered at locations with a heavy Chinese population, while Koran study classes may be given at locations frequented by ethnic Malay users. In addition, PAWEs may offer transportation service, as needed. The learning experiences gained at PAWEs are expected to help senior citizens make positive contribution to the local community.

Each PAWE also carries out an Economic Empowerment Programme (EEP). Designed to help the elderly achieve income security, EEP may involve the production and sale of agricultural produce and other food products, and proceeds from the Programme are used to fund the operational costs of each PAWE.

Each PAWE appoints the regional administrative head of JKMM to serve as advisor. Its management body is made up of government organizations, private companies, social welfare-related organizations and concerned volunteers. The management body is responsible for plan preparation and is required to hold meetings six times a year, and one supervisor and two assistants must be included in the body. At some PAWEs, local resident volunteers play a

part in the operations of PAWEs, joining forces with the members of the management team listed above.

Of the 22 PAWEs currently in operation, 20 locations are run by CWC and two are run by USIAMAS. The government gives financial grants amounting to MYR 33,330 every year per PAWE (In 2011, a total of MYR 733,260 were granted to 22 PAWEs combined). The grants are broken down into salaries for the supervisors (MYR 7,200), salaries for two assistants (MYR 8,400), utilities (MYR 2,400) and meals (MYR 15,330). Meal grants are available only to PAWEs serving meals. Any unused portion of the grant needs not be returned to JKMM and may be carried over to supplement the budget of the following year. Each PAWE is required to submit an activity report to JKMM every three months.

At CWC, its branches are responsible for the operations of PAWEs. However, the branches are not direct recipients of government grants. The head office of CWC receives an annual grant of MYR 33,330 for each PAWE under its umbrella, and CWC allocates budgets to its branches using the grant. Each PAWE pays for labor, public utilities and facilities maintenance out of the funds received.

iv. State of service availability

As illustrated in the table below, there are 22 PAWEs in operation, all of which are run by NGOs under the guidance and supervision of the government. Twenty of them are operated by CWC and the remaining two PAWEs are run by USIAMAS. A total of MYR 733,260 in financial grants was given to support the operation of the 22 PAWEs. A new PAWE is planned for in 2013, and other plans are underway to set up a PAWE in every district, subject to sufficient budget allocations.

Table3-5 List of PAWEs

State	PAWE
Kuala Lumpur	PAWE Cheras Baru,
Kedah	PAWE Kulim PAWE Sg. Petani
Perak	PAWE Tg. Malim
Selangor	PAWE Jenjarom PAWE Sabak Bernam PAWE Kompleks Penyayang Bakti
Negeri Sembilan	PAWE eremban
Melaka	PAWE Alor Gajah PAWE Bukit Baru
Johor	PAWE Muar PAWE Kluang
Pahang	PAWE Pekan PAWE Raub PAWE Bentong PAWE Kuantan
Kelantan	PAWE Kemunin
Terengganu	PAWE Marang PAWE Besut PAWE Dungun
Sabah	PAWE Sandakan
Sarawak	PAWE Miri

2) U3A: University of The Third Age [187]

i. Objectives and Background of the Establishment

University of The Third Age Malaysia was launched in 2008 as one of the programs under the "Lifelong Learning for Older Malaysians" project which is initiated by Prof. Dr. Tengku Aizan Hamid, Director, Institute of Gerontology, University Putra Malaysia. This project was supported by the Government of Malaysia and the United Nations Population Fund (UNFPA) [Country Programme Cycle 2008 - 2012]. [188]

The project was established after receiving an enthusiastic response from the senior citizens in a pilot program conducted by the Institute of Gerontology, UPM known as the Lifelong Learning Initiative for Elderly (LLIFE).

The University of the Third Age Malaysia is a hybrid of the international, British and French models. U3A Malaysia activities are primarily hosted at University Putra Malaysia, but its administration is shared between the Institute of Gerontology and active U3A members who have been providing the input, planning and structure of the program. In mid-2009, U3A

[187] On-site hearing survey on April 26, 2013 (U3A）, University of the Third Age, (2013). Retrieved from http://u3amalaysia.wordpress.com/

[188] University of the Third Age, (2013). "Welcome to UA3 Malaysia". Retrieved from http://u3amalaysia.wordpress.com/2010/03/10/hell

participants appointed a members-only Protem committee to formally register the group with the Registrar of Societies, Malaysia. In October 2010, the Association for Lifelong Learning of Older Persons (U3A) Kuala Lumpur and Selangor was officially registered.

U3A is still running at these two locations.

ii. User eligibility for service and procedures

There are about 300 participants, and the male-to-female ratio is 40 to 60. The relatively high representation of women is attributable to the fact that they were first inducted to classes to accompany their spouses. Retired civil servants, retired employees of private companies and retired self-employed people represent a good proportion of the student body.

Normal members are required to pay an annual fee of MYR 25. Lifelong members pay a fee of MYR 150 upfront with no annual due. Until 2012 the three basic compulsory courses cost MYR 80, and U3A charged MYR 30 per additional course. Beginning 2013, U3A allows members to take as little as one course at the revised rate of MYR 50 per course. If one becomes a full member, the cost of taking three courses becomes MYR 80. People under the age of 55 can take courses as associate members. Some members go to U3A every day. Many retired people remain healthy with ample free time to spend, and lifelong learning gives them opportunities to gain new knowledge and friendships.

iii. Services offered and structure of services

They use the “learning for leisure” concept, where no academic degrees are conferred in the lifelong learning program. Classes are taught by specialists, including university faculty. A diverse number of courses on various subject matters such as adult development and ageing, healthy lifestyles, exercise, languages (English, Arabic, and Mandarin), arts and craft, gardening, cooking, computing, photography, music, dance and singing are offered. [189]

Until 2012, U3A offered two terms per year, but beginning this year, it offers only one term per year, which lasts three months. The number of days classes meet varies from course to course. New course offerings in 2013 include aerobics, Mandarin, French, Japanese, home therapy, and Chinese Medicine.

The cost of running U3A amounts to MYR 80,000 to 90,000 per year. In the last five years, UPM shouldered the cost of operating U3A with a financial grant from the government, which covered about 90% of its operating costs, but the financial grant is no longer available beginning this year. Because it must now fund its operations on its own, it decided to offer only one term this year. As a result, it expects to incur about MYR 70,000 in operating costs this fiscal year. The plan for the next year calls for two terms, which are expected to increase its operating costs to MYR 90,000. One session lasts 1.5 hours and instructors are paid at the

[189] University of the Third Age, (2013).“About Us”. Retrieved from http://u3amalaysia.wordpress.com/about/

rate of MYR 120 per session. Because compensation paid to instructors cannot be covered by tuition alone, the possibility of securing donations and financial grants from the Ministry of Women Affairs earmarked for the elderly and social welfare purposes is under discussion to make up for the shortfall. It is difficult to increase tuition since the elderly do not have income flows.

The chair is elected by the directors and serves two years in office. When U3A was launched in 2007, UPM invited applications for the posts of directors publicly. The chair and the directors serve U3A without pay.

Lifelong learning falls under the jurisdiction of the Ministry of Higher Education and the Ministry of Women Affairs. Community colleges have been established in many parts of the country but none targets solely senior citizens. In addition, a number of courses are one-day courses. The government has not reached the point of readiness to put in place a solid model for lifelong learning.

3) Examples of services

Below, several PAWEs operated by CWC under the government's financial grant will be examined, in addition to NCSCOM's day centres, which aim to serve, without financial grants from the government, as a community space encouraging social participation and a place to find purpose in life.

a) PAWE run by CWC (an NGO) (State of N.Sembilan) [190]

Situated next to the premises of an old folks home built 40 years ago, this PAWE opened its door in 2002. The PAWE is visited not only by neighboring residents but also by the residents of the old folks home next door. The target users are healthy senior citizens aged 56 and above. Because of its location in a predominantly Chinese area, many of the users are ethnic Chinese. Currently, registered users number in excess of 200, and male and female users are represented equally. Many users are residents nearby, who come to the PAWE on foot or by motorcycle, among other means. Many spend time at the PAWE while their family members are off to work.

Users may take any classes of their choice free of charge. The PAWE's staff do not offer counseling to users by developing an understanding of the users' needs.

Once registered as members, no members quit (No maximum term of membership. No system of "graduation" in place).

The PAWE is open from Monday through Friday every week from 8:00 a.m. to 5:00 p.m.

[190] On-site hearing survey on November 13, 2013 (Activity Center PAWE in N.Sembilan)

Class offerings include Tai Chi, gym, harmonica, karaoke, arts and handicrafts and cooking (dumplings, moon cakes). The PAWE offers classes only and no meals are provided.

Two permanent staff are available, one of which is the supervisor. Both have completed the training program run in collaboration with JKMM and CWC.

The PAWE's construction was financed by the budget of JKMM and is run by CWC under the financial grant from JKMM, which amounts to MYR 33,000 per year. It does not engage in charity sales to fund its operation. It pays instructors at the rate of MYR 100 per month.

At the monthly meeting of the committee members, it discusses program structures, among other matters. The committee is comprised of the landlords of the PAWE, those nominated from among CWC members and those appointed by JKMM, in addition to former village mayors, among others. Committee members double as volunteer staff. The PAWE files a state-of-business report in the prescribed format on a periodic basis. It is also subject to periodic auditing.

This is the only PAWE in the state, and no other places offer similar activities in the surrounding areas. JKMM has decided to build another activity center within the State according to its plan for 2013.

b) PAWE run by CWC (an NGO) (State of Melaka) [191]

The PAWE was launched in 2008 and is housed in the nation's first multi-facility complex. A variety of facilities under the charge of JKMM, a day care centre for the disabled, a liaison office of JKMM (which accepts applications for allowances for the elderly and the disabled, among others), and the Administration Office have been set up on the same premises. The then-state governor of Melaka proposed the idea of building a multi-complex to the central government, which went ahead with the proposal as a pilot project. This PAWE is known as the most active centre, and it even serves as a forum of exchange with the disabled users of another centre in the same complex.

The accumulated total of registered members is 137 (male: 99; female: 33, deceased: 5). Thirty-three members make regular visits to the PAWE, and their ethnic mix is 32 Malays and 1 Indian, with no Chinese. The mix is due to its location in a predominantly Malay area. Visitors may participate in any class of their choice. They come and leave the premises as they like. Users must pay MYR 10 upfront at the time of registration but pay no fee thereafter for the use of the PAWE.

The PAWE is open from 8:00 a.m. to 5:00 p.m. Programs offered include birthday parties, Senior Citizens' Day celebration, charity activities, visits to other activity centres, festivals, outings, counseling, sports family day and, singing contests. Four permanent staff

[191] On-site hearing survey on November 14, 2013 (Activity Center PAWE in Melaka)

(Supervisor, Assistant Supervisor, Cook, and Cleaning) are on duty. The supervisor is selected from the community. The PAWE's committee consists mainly of landlords, and committee members also participate in activities as volunteers.

As part of the Economic Empowerment Programme (EEP), the PAWE is engaged in the production and sale of frozen food. Every Tuesday, participants gather there to prepare dumplings (4MYR per bag), samosa (5MYR per bag), roti (3MYR for 6 slices) and pancakes (3.5MYR for 9 pieces), among others. Proceeds do not go to participants. Instead, proceeds are used to purchase ingredients and to pay for the expenses of running various events by the PAWE. These products are also on sale during a variety of events, which the PAWE organizes from time to time, and they are well received by local residents and sell fast. JKMM has donated a refrigerator in support of the activity.

c) PAWE run by CWC (an NGO) (State of Selangor) [192]

The PAWE went into service in 2000. Users are senior citizens aged 60 and older, and the ethnic Chinese account for 99% of the users. The remaining users are ethnic Indians. Users are not charged for the use of the PAWE. There are over 400 registered users, of which about 150 users use the PAWE on a regular basis.

Users come to the PAWE twice in a single day. Users' daily schedule, if loosely put, includes Tai Chi and exercise from 8:00 a.m. and tea time from 10:00 a.m. Users go back home, have lunch at home and come back to the PAWE at 2:00 p.m. for exercise from 3:30 p.m. to 4:30 p.m. The Centre closes at 5:00 p.m. and users are allowed to stay longer for karaoke, and other activities.

The frequency of visits varies from user to user, but people typically stay home at least two days out of one week, since the time spent with family members is crucial.

The PAWE is open from 8:00 a.m.to 5:00 p.m. and is closed on Sundays. Its programs include Tai Chi, reading and writing, Chinese, Chinese chess, exercise (offered in the morning and in the late afternoon) and karaoke. PCs are also available for use and the staff are ready to assist users. The PAWE grows herbs and vegetables on the premises, and users make herb tea for their own enjoyment.

The PAWE sells vegetables harvested on the premises as part of its EEP. Monthly proceeds amount to about MYR 60 to 70, of which 50% is used to purchase planters and other supplies for the vegetable garden. The rest partially funds the maintenance cost of the PAWE. No financial support or assistance in kind is provided by JKMM for this purpose.

If any regular user stops showing up, the PAWE makes the point of grasping the situation faced by the user by asking the user's neighbors.

[192] On-site hearing survey on November 15, 2013 (Activity Center PAWE in Selangor)

There are three permanent staff. One is a staff member of CWC and is not paid. The remaining two are part-time workers. JKMM has distributed one vehicle to each of the states. If there is only one PAWE in the given state, the PAWE is entitled to use the vehicle.

d) Day centres run by NACSCOM [193]

NACSCOM operates day centres for the purpose of assisting the elderly find a place where they comfortably belong, build friendship and improve their well-being. The centres allow users to turn their idle time into time for reaping health and other benefits, through participation in a variety of activities such as PC, karaoke, line dance, Tai Chi, badminton, ballroom dance, calligraphy, languages, singing, health-related lectures, music, games and health checks, among others. The centres are located in four areas: Damansara Jaya, Kota Damansara, Subang Jaya, Setapak, with an additional location under construction in Kota Kinabalu, Sabah.

Its day centres are open daily from 9:00 a.m. to 5:00 p.m., giving about 20 classes every week. The class tuition ranges from MYR 40 to 180 per course per month, but classes yield little profit, as the majority of proceeds from the participants goes to instructors in the form of compensation. The centres in principle accept users aged 60 and over, but younger people may use the centres as well. Each day, the centre is typically visited by 30 to 40 users, and the majority of users are ethnic Chinese. The centres take out ordinary insurance for injuries.

Its day centres are not registered or regulated by the government of Malaysia. Ethnic Malays are little represented in the user base, which may be explained by the fact that Malay families are more willing to care for their elders themselves and that day care centres typically do not serve halal meals.

Meanwhile, NASCOM with the co-operation with IBM set up 14 Life Long Learning Centres where older people can learn how to use computers. These centres are located at SCC Subang Jaya, Taman Mayang Jaya, SCC Batu Pahat, SCA Johor Bahru, SCA Melaka, SCA Sungai Petani, SCC Sitiawan, SCA Kelantan, SCA Teluk Intan, SCA Damansara Jaya, SCA Kota Kinabalu, Setapak Day Centre, Kota Damansara Day Centre, SCA Likas, Kota Kinabalu.

(5) Caring for the elderly and prevention of age-associated loss of autonomy through mutual help

Care for the elderly and care designed to prevent age-associated loss of autonomy are

[193] On-site hearing survey on March 18, 2013 (NACSCOM)

administered not only by the government, NGOs and private companies (public and private assistance) but also by the local community in the form of mutual help among neighbors. For instance, if one wishes to take advantage of the home help service, one must apply at the regional office of JKMM. In addition to applications personally filed by the persons in need of care, the office may receive tips from village headmen about elderly residents requiring assistance. Some current recipients of home help service relied on help offered by neighbors before they link with public or private help service.

Home care service and PAWEs may be perceived as systemic versions of grassroots mutual help, as these formal services also rely heavily on neighboring residents as volunteers.

3.4. Key challenges

(1) Defining care levels and service standards for elderly care with a view toward establishing comprehensive rules applicable to services offered by facility services for the elderly

For services offered at facility services, a comprehensive set of standards must be established for facility structures, staff allocation and operational standards, among others, in order to secure service quality required for residents in need of a moderate degree of assistance, to achieve quantitative expansion, to implement medical care under a certain degree of oversight, and to secure human resources.

In drafting and improving comprehensive rules for facility services, care levels for the elderly must be defined, and the residents of the existing facility services must be classified according to the care levels, based on which priority is established to determine who should be admitted to facility services. The service standard for the nursing homes registered with the government is extremely high, and yet a small number of residents is highly independent requiring little assistance in daily activities, suggesting inefficiency in service delivery. The government needs to prepare and improve comprehensive rules applicable to facility services by first identifying the user group for whom service enhancement is most needed.

(2) Enhancing home help service for people requiring care

For Malaysia to achieve “Ageing in Place,” as advocated by the government, a community-based care structure that does not rely on facility services must be built. Now that day care centres, which previously aimed to provide rehabilitation training and respite were transformed into PAWEs in an effort to enhance support for the elderly capable of taking care of themselves, home care service is primarily centered on home help service, and its

importance is growing.

Home help services are operated by the government and NGOs. The level of care provided by NGOs varies, as some NGOs provide care for the mildly incapacitated, while others are willing to extend care to people with moderate to severe incapacity. The services offered by NGOs also vary from assistance in IADL to ADL assistance. Volunteer staff play a crucial role as service providers.

One of the objectives of home help service is to assist the elderly and the disabled so that they can keep on living in their own home and to remain an active member of the family and society. To translate this into reality, the provision of physical care, alleviation of burdens shouldered by family caregivers, and maintenance and improvement of a person's functionality essential for daily living are the issues that need to be addressed. Hence, efforts must be made to better manage the services provided and to ensure service quality by setting up guidelines and by rolling out enhanced training for volunteers.

(3) Encouraging visits to PAWEs and utilization of PAWEs as a referral point to more care services

PAWEs, which cater to independent seniors, are growing in number under the plan calling for a PAWE in every district. The key objective of PAWEs is to encourage social participation and to help members find purpose in life. In this regard, PAWEs have achieved a certain degree of success in providing a comfortable place for seniors living nearby by offering activities and programs that are geared to the unique needs of the community. However, the Economic Empowerment Programme, an initiative aimed at helping the elderly earn a living, has produced little benefit to the elderly, as the Programme has been turned into a means to fund operating costs for PAWEs in practice, and makes little contribution to the elderly seeking employment or income by acquiring new skills or knowledge.

PAWEs' function as a community space for social participation and a place to find purposes in life allows PAWEs to spot members with deteriorating bodily or mental functionality, and growing hopes are placed on this function, as this can facilitate early detection and early referral of the people in need of assistance to appropriate care providers. Some PAWEs have already initiated member monitoring. If a regular visitor to the PAWE stops coming, the PAWE makes inquiries to the member's neighbors to obtain health-related information such as hospitalization of the member. Monitoring has critical implications for the elderly living alone or socially withdrawn, who are unable to seek out the help they need. To make the most out of the role played by PAWEs, the elderly should be encouraged to sign up at PAWEs and a stronger channel of cooperation between PAWEs and JKMM should be established.

It should be noted that there may be senior citizens' clubs and other undertakings already

in operation, which, like PAWEs, serve as a place for social participation and a place to help the elderly find purposes in life. Financial grants for PAWEs are directed mostly to CWC, which operate 20 PAWEs, but there are NGO-initiated day centres including those run by NACSCOM, which operate without governmental funding and still deliver the same functions offered by PAWEs. The exact number and accurate activity details of the self-initiated centres that receive no financial grants from the government are not known. To expand and improve service efficiently, it is important that full studies on organizations similar to PAWEs be made, and financial grants be made available across the board, including the centres run by smaller NGOs.

(4) Fostering and securing of caregivers

Malaysia has no system of certifying or licensing caretakers as certified or licensed vocational caregiving specialists. Nursing homes hire people as “personal care aides,” who, as unlicensed assistive personnel, provide help ranging from transfer (mobilization), wake-up and morning assistance, bathing, eating (excluding tube-feeding), toileting, dressing and assistance in day-to-day living, to checking body temperature, pulse and blood pressure, medication management and psychological support, under the supervision of nurses that have undergone training in elderly care. For the training of volunteers, who work primarily as home help service providers, JKMM is examining the possibility of structuring a unified training program to teach care for the seniors, care for the disabled and counseling support, among others but there is no standardized textbook as of date, and volunteers’ learning is limited to sharing of experiences and cases.

Care for the elderly can be classified into interventions that should be administered by medical and nursing professionals, interventions for physical assistance requiring special caregiving skills, and care required no special skills such as housekeeping, senior sitting and conversation companionship. The differences among the three categories must be well understood before mapping out plans for the personnel that need to be secured for each type of services and programs designed to foster and develop such personnel.

4. Social Security System

4.1. Health Security

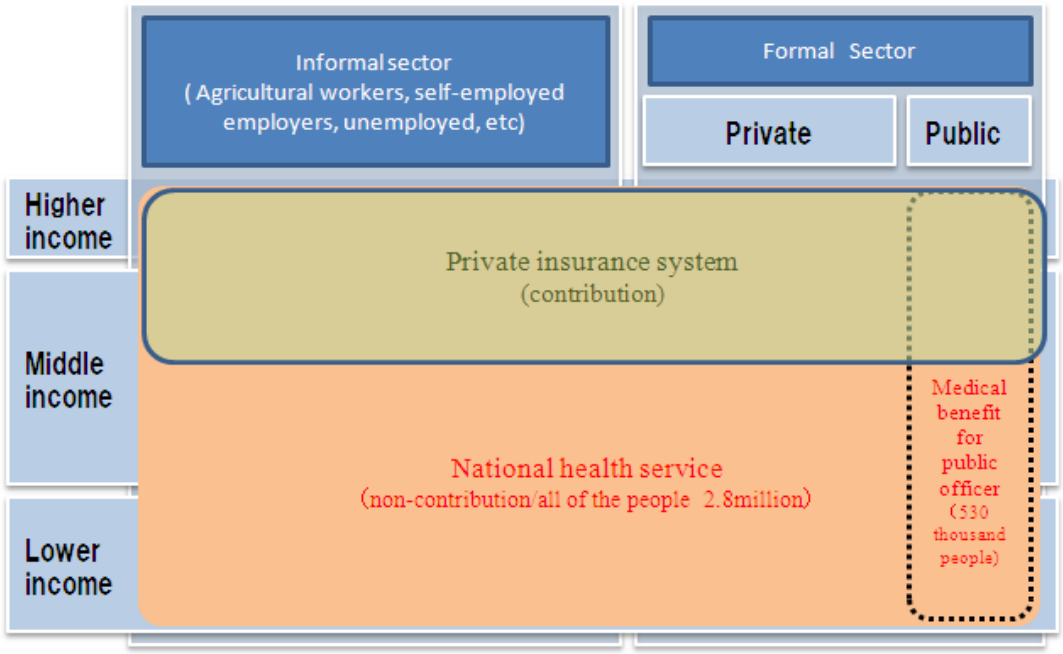
(1) Outline [194]

In Malaysia, health care services are provided through a tax-based system, and there is no public health security system operated by a social insurance scheme. Therefore, there is no specifically named social security scheme.

While there is public health care services which is available for low out-of-pocket expenses, private health insurance systems play an important role, as they are often used by the wealthy (including some types of government officers) that can afford them. At present, the government is considering the creation of a national health insurance scheme based on a social insurance system, and careful discussion is underway, taking into account the potentially significant impacts that such a scheme may have on the private health insurance market and the operation of private medical institutions.

Even in the basically free health care services, patients need to pay for some medical services and must shoulder a heavy cost burden. In this regard, the free services are in fact not free. On the other hand, there exists a gap between the above-described system and that for government officers, because the health security system for government officers covers the expenses of medical services that are not covered by public medical services. This indicates that, although a health security system with universal coverage is formally in place, there are many issues that need to be improved.

[194] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, IV-1.



Source: Compiled by Mitsubishi UFJ Research and Consulting

Figure 4-1 Outline of the health security system in Malaysia

(2) Organizations Involved in Social Security (Public Organizations, Private Companies, NGO)

1) Roles and Functions of Major Related Institutions

a) Public Service Department of Malaysia (Jabatan Perkhidmatan Awam Malaysia [JPA]) [195]

The JPA is responsible for health security and the pension scheme for government officers.

In order to improve organization and promote the development and management of human resources in public services, the JPA aims to: (1) engage in human resource management in the public service sector and in advisory services for government agencies, (2) restructure or enhance the organization and develop high-quality, competent, and innovative personnel, (3) manage labor management relations to realize harmonious workplace environments, and (4) improve the system and work processes through the use of ICT.

There are three pillars of its function: planning, development, and management. In the planning aspects, the JPA determines the roles of the public sector, studies the size and structure of public institutions, studies the pension scheme, and other matters, for government officers, defines the roles of the private sector and the public sector, and

[195] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, IV-5 (3).

constructs strategic networks, and others. The development function includes the formulation of organizational development policy, the provision of career paths, and the determination of training policy, and others. The management function involves the appointment and assignment of personnel, the management of remuneration, promotion, retirement benefits, work conditions, labor management relations, education, and the human resource database, the evaluation of the target achievement level, and monitoring activities.

b) Medical Institutions (Public, Private)

i) National plans for the health security sector

In Malaysia, where health care services are provided by public medical institutions almost free of charge, universal coverage has been formally realized. In reality, however, people in the middle and upper classes purchase private health insurance and receive health care services of higher quality—a situation that is causing health disparities. The government is also aware of the limits of providing services through the tax-based system modeled on U.K.'s NHS (National Health Service) and is now seeking a shift to a social insurance system. [196]

As a national plan for the health security sector, Malaysia develops a "Country Health Plan" every five years. Currently, the *10th MALAYSIA Health Plan* (10MP) is in effect. Malaysia also set forth "Vision 2020" as a key policy, under which the country sets the target to become an advanced country by 2020 and is now working on the improvement of the health security system to meet the standard of advanced countries, all under the slogan of "1 Care for 1 Malaysia."

Table 4-1 Key policies of the *10th MALAYSIA Health Plan (2011–2015)* by the Ministry of Health

【The main key result area by MOH】 (1) Health sector transformation towards a more efficient and effective health system in ensuring universal access to healthcare (2) Health awareness and healthy lifestyle (3)Empowerment of individual and community to be responsible for their health
【Strategy】 Strategy (1) Establish comprehensive healthcare system and recreational infrastructure Strategy (2) Encourage health awareness & healthy lifestyle activities Strategy (3) Empower the community to plan or implement individual wellness programme (responsible for own health) Strategy (4) Transform the health sector to increase the efficiency and effectiveness of the delivery system to ensure universal access

Source: Compiled based on *Country health plan 10th Malaysia Plan* by the Ministry of Health Malaysia

[196] According to an interview with the MOH.

ii) Salient features [197]

The health care system of Malaysia is based on the NHS of the former colonial power of the U.K., under which all public medical institutions provide health care almost free of charge. In principle, there is a reference system.

In general, most people only visit public medical institutions for cost reasons. At such public medical institutions, many people must wait to see a doctor, and the quality of health care is considered to be low. Private medical institutions provide relatively higher-quality health care and have less patients waiting. However, those who use the services of private medical institutions have to pay all the expenses or must purchase private health insurance. Therefore private medical institutions are used only by the middle- and higher-income classes that can afford to pay the costs of health care services or purchase private health insurance, while most people visit public medical institutions.

Medical institutions in Malaysia include public medical institutions and private or NGO-operated medical institutions. While there is a nationwide network of public medical institutions operated by the MOH, private hospitals also assume an important role in delivering health care mainly in urban areas.

Table 4-2 Medical institutions in Malaysia [198]

		Government	Private
Hospitals		**131**	**217**
	Number of beds	33,211	13,186
Clinics [199]		2,833	6,442
Placement ratio of doctors		Approximately 50%	Approximately 50%
The ratio of patients		Approximately 75%	Approximately 15%

* The ratio of patients shown is the ratio to the entire population, as based on an interview with a person in charge at the MOH. It is estimated that the remaining 10% of patients is treated by traditional medicine rather than medical institutions.

[197] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, pp. IV-10-12.
[198] MOH (2010) Health Facts Malaysia 2010.
[199] Including community clinics/Klinik Desa and maternal and child health clinics; according to a person in charge at the MOH, there are about 800 medical clinics.

Table 4-3 Public medical institutions in Malaysia

Medical institutions		Number	Number of beds (official)
Under MOH			
	Hospitals	131	33,211
	Special Medical institutions	6	4,582
	Special institutions[*1]	15	-
	National institutions of health	6	-
	Dental Clinics[*2]	34	341
	Mobile Dental Clinics[*2]	25	42
	Health Clinics[*3]	2,833	-
	Health Clinics (1 Malaysia)	53	-
	Mobile health Clinics& Teams	165	-
	Mobile health Clinics& Teams (1 Malaysia)	3	-
	Flying Doctor stations	13	-
Not under MOH			
	Hospitals	8	3,690

[*1] One national blood center, four public health research institutes and 10 food quality research institutes

[*2] The number of beds is the number of dental chairs.

[*3] Including community clinics/Klinic Desa, mental clinics, and maternal & child health clinics

Source: Compiled based on Health Facts 2010 by the Ministry of Health Malaysia

In total across the country, there are 131 hospitals with 33,211 beds under the jurisdiction of the MOH, eight government-affiliated hospitals with 3,690 beds outside the jurisdiction of the MOH, and 217 private hospitals with 13,186 beds (as of 2010).

As for the institutions providing basic outpatient care and public health services, the MOH operates community clinics/Klinik Desa (which provide maternal and child health services, treatment for minor injuries, and first aid in the community), maternal and child health clinics (specialized in maternal and child health services), mobile clinics, and health clinics (which provide a wide range of health services to local residents in wider areas).

Table 4-4 Private medical institutions in Malaysia

Facilities		Number	Number of beds (official)
Licensed			
	Hospitals	217	13,186
	Maternity Homes	22	97
	Nursing Homes	12	263
	Hospice	3	30
	Ambulatory Care Centre	36	125
	Blood Bank[*1]	5	-
	Hemodialysis Centre[*2]	191	2,195
	Community Mental Health Centre	1	9
Registered			
	Medical clinics	6,442	-
	Dental clinics	1,512	-

[*1] Four cord blood stem cell banks, one stem cell bank, and one regenerative medicine research center

[*2] The number of beds is the number of dialysis chairs.

Source: Compiled based on Health Facts 2010 by the Ministry of Health Malaysia

Table 4-5 Number of inpatients and outpatients

Type of medical institution			Admissions	Outpatient attendances
Government	Under MOH			
		Hospitals	2,121,923	17,550,603
		Special Medical Institutions	8,640	102,944
		Public Health Facilities	_	27041,812
	Not under MOH		132,010	2,070,036
Private			869,833	3,174,124

Based on the result of a survey conducted with private health organizations and facilities (response rate: 98.44%)

Source: Compiled based on *Health Facts 2010* by the Ministry of Health Malaysia.

c) Insurance Companies, Insurance Associations

i) National Insurance Association of Malaysia (NIAM) [200]

This is referred to as “Persatuan Insurance Kebangsaan Malaysia” in Malay. NIAM was established as an industry organization in 1973 under the Societies Act 1966.

At present, it has 34 members, including 14 general insurance companies, four multiple-line insurance companies, five life insurance companies, seven Takaful companies, [201] and four reinsurance companies. The objectives of the association are the furtherance and protection

[200] http://www.niam.org.my/niam.html

[201] “Takaful” is an insurance system based on the teachings of Islam. It is established under the rules prescribed by the Bank of Negara (the central bank). No incentive is provided by the government. Takaful is often provided for by JVs with foreign companies. All Takaful companies except for the 1–2 locally based companies consist of joint ventures with foreign companies.

of the profits of its members, the promotion of its collaborative activities, and the enactment of laws and regulations, and others. NIAM is different from LIAM, which described below, in that its members are composed of locally based companies (including foreign-affiliated joint venture companies).

ii) Life Insurance Association of Malayisa (LIAM) [202]

This is referred to as “Persatuan Insurans Hayat Malaysia” in Malay. LIAM was established as an industry organization with the objectives of raising people’s awareness regarding life insurance, promoting various awareness-raising and educational activities, making suggestions to the policy section for the sound development of industry, and establishing internal control regulations, and others. At present, 17 life insurance companies including foreign-affiliated companies are members of this association.

2) Division of Roles between public and private sectors

a) Relations between Public and Private Medical Institutions

The Medical Security System in Malaysia is composed of medical services provided by non-contributory public medical institutions and by private medical insurance in private medical institutions.

[202] http://www.liam.org.my/index.php?option=com_content&view=article&id=54&Itemid=84

Table 4-6 Basic structure of the health care system in Malaysia

	Public healthcare service	Medical benefits of GP	Private insurance
Started	--	1980	--
Basis laws	--	Pension Act 1980	--
Competent authority	MOH	JPA	Central Bank of Malaysia、MOH
Administration organization	MOH	JPA	Private insurance companies
Scheme	Non-contribution scheme	Contribution scheme	Contribution scheme
Target group	All the people	Public officers and their families	Voluntary (Upper and middle income group)
Apply to Dependents (family members)	Yes	Yes	Based on a contract
The number of members	Approximately 28 million	Approximately 530 thousand	Estimates approximately 8.4million (30%of the population)
Referral system	Yes	N.A.	None
Out of pocket	・Outpatients pay about 1 MYR per visit ・Inpatients pay almost free of charge .	・benefits are paid for treatment of specific diseases in private hospital which is not treated in public hospital,	・Patients cover all expenses. ・Some private companies purchase insurance program for companies as a welfare program for employee
Annual medical expenditure [203]	13,546 million MYR (Public expenditure on health,2007)	--	16,682 million MYR (Private expenditure on health,2007)
Requirement to receive benefit and medical practice to be excluded	・To receive benefit the insured has to be treated in public hospitals. ・The expensed for purchasing specific medical equipment is not covered.	・This covers the expenses for medical equipment and extra bed charge that is not covered by public healthcare service.	・Depends on the contract with insurance company. ・Extra charge for high cost medical services that exceeds the limit of benefit is not covered, because there is limit in total amount of insurance benefit in lifetime.
Others	--	--	.Regarding private health insurance plan, there is the regulation of MOH and the Central Bank that individuals can receive tax deduction when they take out insurance.

Annual medical expenditure: MOH "Country Health Plan 10th Malaysia Plan 2011–2015"

Source: Compiled by Mitsubishi UFJ Research and Consulting based on an interview with the persons concerned, etc.

[203] MOH's *Country Health Plan 10th Malaysia Plan 2011–2015*

(3) Major Services and Support

1) Tax-Based Non-Contributory Medical Services Provided by Public Medical Institution [204]

In Malaysia, primary care services are provided by public medical institutions for little or no charge, and thus a health security system with universal coverage is formally in place. This system is a tax-based non-contributory system funded by taxes under which 98% of total medical costs of public medical institutions are covered by public funds. Usually, patients pay approximately MYR 1 per visit for primary care. As for secondary and higher lever care, too, almost free services are the standard for the most part, and patients need to pay only for specific types of health care services.

However, due to long wait times and the low level of public health care services, people in the middle and upper classes purchase private health insurance and, as a result, health disparities do exist. In order to improve the current situation, the government is looking to improve the service quality of public medical institutions. At the same time, the government is aware of the limits of non-contributory health security systems from a sustainability perspective, and the MOH is now seeking a shift from a tax-based health care delivery system to a social insurance system.

2) Services Provided by Private Medical Insurance in Private Medical Institutions

a) Perception to Private Medical Insurance

In Malaysia, private insurance products are purchased mainly by middle- and higher-income people, it is estimated that the number enrolled accounts for approximately 30% of the total population. [205] Some purchase a medical insurance policies only, while many of them purchase health insurance as a supplement to their life insurance policy. In general, companies above a certain size tend to provide coverage to employees as part of their welfare program. In this case, however, it is difficult for employees to keep the same coverage option of insurance for corporation when they retire. So, employees purchase insurance products on an individual basis before retirement in order to prepare for life after retirement.

In addition, a fairly large number of government officers also take out private health insurance since they can chose insurance coverage options based on their individual circumstances.

On the other hand, a certain group of people do not see much need for private health

[204] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-13 (4).

[205] This figure is not the actual number of the insured persons but the number of policyholders of private insurance companies including both health and life insurance. Considering that many people take out more than one insurance policy, the accurate number of the insured is unknown.

insurance. Even without health insurance, the medical costs charged by private medical institutions are only MYR 40–50 per visit or MYR 70–100 in urban areas. Therefore, some middle-income people are skeptical about the benefit of paying for private insurance.

b) Procedure of Private Medical Insurance

When a patient presents the insurance card for private health insurance (the “Medical Card”) to a medical institution, a health insurance benefit is paid according to the coverage of the insurance product that the patient is receiving. When a patient not holding any private health insurance is hospitalized in a private medical institution, the patient usually needs to deposit about MYR 3,000 prior to hospitalization. This deposit is not necessary if the patient presents the Medical Card to the medical institution. The costs of medical care are paid by the insurance company to the extent covered by the insurance package.

In Malaysia, where private health insurance is frequently used, it is important to be able to confirm quickly that the patient is covered by private health insurance in promoting the sale of insurance products. Therefore, Managed Care Organizations (MCOs) are established as organizations that confirm the validity, and other aspects of the Medical Card. MCOs are financed jointly by insurance companies, each of which provides data to an MCO on those insured, including their name, the insured number, the validity of the Medical Card, and the type of insurance coverage held. When an insured person visits a medical institution, the medical institution confirms the validity of the Medical Card via an MCO portal site.

Presently, there are more than 10 MCOs in Malaysia (including three major companies). In some cases, major insurance companies such as ING operate MCOs for themselves.

Table 4-7 Major insurance-related associations in Malaysia

Name	Missions	Number of members
National Insurance Association of Malaysia (NIAM)	・To promote and safeguard the interests of members in all their activities. ・To promote or undertake any project which will enhance or contribute to the standing and reputation of its members in society ・ To secure and support the promotion of Bills in Parliament which will protect the interests of or be advantageous to its members	34 companies Comprising 14 general insurance companies, 4 composite insurance companies, 5 life companies, 7 tactful operators and 4 reinsurers.
Life Insurance Association of Malaysia (LIAM)	・To promote public understanding and appreciation for life insurance ・To enhance the professionalism of staff and agents through continuous training and education ・To formulate rules and guidelines to instill good business practice ・To improve the image of the life insurance industry through self-regulation.	17 life insurance companies (Include foreign companies)

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the websites of NIAM and LIAM.

c) Market Outlook for the future

The private insurance market in Malaysia is still in the developmental stage. Although health insurance is widely known by the citizenry, the necessity of such insurance is not fully recognized. This seems to be because, while public health security services form the important basis of health care services in Malaysia and are trusted by the users, to some extent, the fact that it is difficult to receive advanced care only by using the public health care services has not been widely recognized. [206]

In addition, the insured persons under private health insurance that are registered through a corporate contract do not fully understand that they have to surrender their insurance policy under a corporate contract after retirement and that it is difficult to take out a health insurance policy on an individual basis. [207] In particular, the younger generations tend to have a weak sense of crisis regarding the preparation for life after retirement.

[206] According to an interview with NIAM.

[207] Therefore, a large number of employees who are insured under a corporate contract also take out insurance on an individual basis.

3) Medical benefit of the government officers' pension scheme

Government officers can receive specific types of medical care also for free, as part of the medical benefit under the government pension scheme. In addition, they can receive medical care that is not available at public medical institutions but that is available only at private medical institutions if they have a letter of reference or a prescription issued by a government medical officer.

(4) Issues Facing Health Securities

1) Disparity between Public and Private Medical Institutions [208]

Public medical institutions, which provide most health care services free of charge, are so crowded that the quality of services has been declining. While the number of doctors working at public institutions is almost the same as those working at private medical institutions, 75% of all patients visit public medical institutions, while 15% visit private medical institutions. Public medical institutions are also facing the issue of the "brain drain" of doctors. Doctors tend to transfer to private hospitals where they are better paid, after gaining experience at public medical institutions. In addition, the above-described situation where doctors at crowded public institutions need to work hard accelerates the transfer of doctors from public to private medical institution and results in further doctor shortages and crowding at public institutions. Thus, a vicious circle arises.

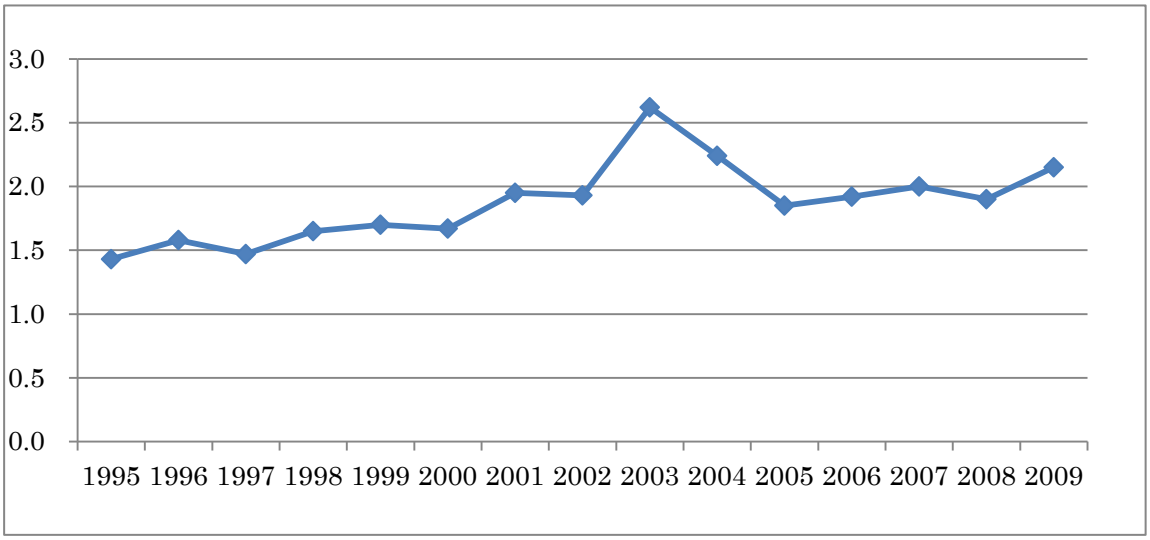
As it is generally recognized that private medical institutions provide better health care services than public institutions, more than a few people choose private medical institutions even though they must pay for the services. As result, a larger proportion of people purchase private insurance than in other ASEAN countries. Thus, there are some cases where low-income persons who cannot afford private insurance spend all their savings to receive medical care at private institutions and then fall into poverty. They can withdraw savings from Account II of the EPF to pay for medical costs, though the amount available is limited. Usually the funds are allocated to savings for old age and home purchase costs, and others, [209] with little left over for medical costs.

The government intends to work on the improvement of the quality of services provided by public medical institutions in a bid to redress the disparity between public and private medical institutions. However, under the current system of free services, there is a concern

[208] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-7 (1).

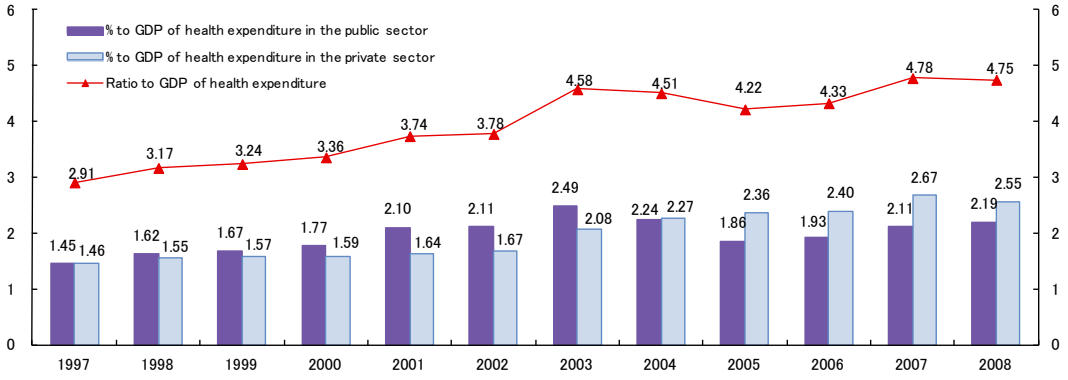
[209] The persons concerned at each organization say that the shift of the EPF to health insurance is unlikely. This is probably because they strongly recognize that the EPF basically functions as an old-age benefit system to prepare for retirement.

that public institutions will become more crowded, as more patients will concentrate in such institutions.



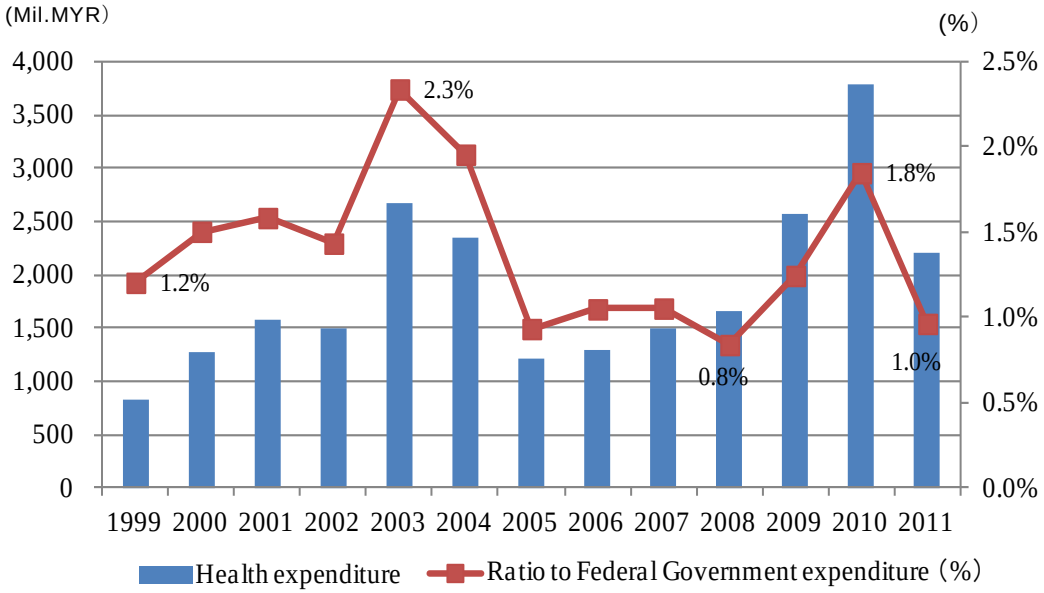
Source: Compiled based on the data of the MOH.

Figure 4-2 Public health expenditure as % of GDP



Source: Institutionalization of national health accounts in Malaysia (Oct 2010)

Figure 4-3 Ratio to GDP of health expenditure in the public/private sector



Source: Compiled based on data of the MOF.

Figure 4-4 Ratio of health expenditure to Federal government expenditure

a) Issues facing the introduction of social insurance systems [210]

Arguments about the provision of public health security services through the introduction of a social insurance system have already begun from the viewpoint of securing a source of revenue. However, the government maintains a cautious stance for the reasons described below.

The government thinks it will be difficult to obtain people's understanding over the significance of paying consultation fees or insurance contributions, as they have been receiving public health care services almost free of charge. The method of collecting contributions from the low-income bracket and informal sector workers, such as the self-employed, farmers, and fishery workers, and the amount of contributions are also at issue.

Substantial changes in private insurance services will be also required. At present, private insurance products, mainly blanket insurance, are taken out by some people. If a social insurance system is introduced, it would be inevitable that private insurance companies review the contents of their products and the terms of the payment of insurance contributions. Although private insurance companies show a willingness to flexibly respond to government policy, a considerable burden is expected for them during the transition period.

The private insurance market is still in its developmental stages. As a system change would be more difficult to carry out when the market expanded, the government recognizes the

[210] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-38.

necessity of introducing a social insurance system at an early date. [211]
[212]。

b) Introduction of Social Insurance in Health Care [213]

The disparity between public and private medical institutions has already become obvious. It is difficult to maintain the current non-contributory system while improving the quality of the services of public medical institutions. In addition, several outstanding issues remain to be solved in connection with the introduction of a social insurance system in health care, including the relief of low-income persons, the balance between social insurance and private insurance, and the method of collecting insurance contributions, and so on.

c) Establishment of Social Security System for the Elderly [214]

As the aging of the population is not a serious problem, with a population aging rate of around 6%, the elderly people are supported by care by family members and the volunteer activities of community groups, charitable organizations, NPOs, and local communities, and others.

In Malaysia, the elderly population is going to increase gradually, and the rate of elderly people as of 2020 is projected to be 8.9%. However in the middle and long term, it is likely that people would expect higher quality service for the elderly because of the further improvement of income levels. As the issues of livelihood support, long-term care, and income security for the elderly are expected to come to the fore in the near future, the government is required to promptly establish a mechanism of welfare provision for the elderly.

4.2. Income Security

(1) Outline of Income Security [215]

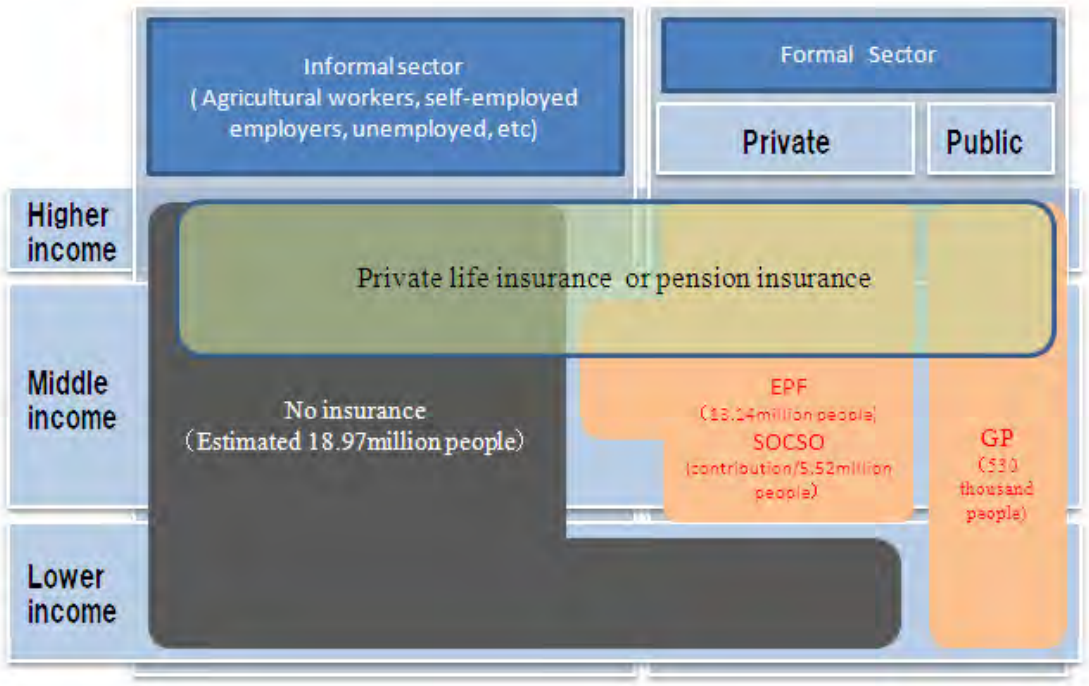
The income security system consists of the GPF (operated by the JPA), which is a social security scheme for government officers, and the EPF and SOCSO, which are for the employees of private companies.

The EPF is a compulsory funding scheme in which employees and employers contribute a prescribed portion of wages, and in which employees receive benefits when retiring.

[211] According to an interview with the MOH.
[212] According to an interview with the MOH.
[213] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-41.
[214] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-41.
[215] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-2 – IV-3.

Employees can also draw on some funds when they buy houses or receive health care, or when their children go on to higher education, and so on.

SOCSO mainly pays for the workers' compensation pension for bereaved families, disability pension, and education loan benefits, and the like. Malaysia does not have an unemployment insurance scheme.



※1:Overlapping members are included.
※2:According to "SOCSO annual report", the number of registered employees is approximately 13.83 million. This is the number of workers registered with SOCSO from the beginning.
Source: Compiled by Mitsubishi UFJ Research and Consulting

Figure 4-5 Outline of pension and other income security schemes in Malaysia

(2) Organizations Involved in Social Security (Public Organizations, Private Companies, NGO)

1) Roles and Functions of Major Related Institutions

a) Public Service Department of Malaysia (Jabatan Perkhidmatan Awam Malaysia [JPA]) [216]

The JPA is responsible for health security and the pension scheme for government officers.

In order to improve organizations and promote the development and management of human resources in public services, the JPA aims to: (1) engage in human resource management in

[216] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-5 (3).

the public service sector and in advisory services for government agencies, (2) restructure or enhance the organization and develop high-quality, competent, and innovative personnel, (3) manage labor management relations to realize harmonious workplace environments, and (4) improve the system and work processes through the use of ICT.

There are three pillars of its function: planning, development, and management. In the planning aspects, the JPA determines the roles of the public sector, studies the size and structure of public institutions, studies the pension scheme, and so on, for government officers, defines the roles of the private sector and the public sector, and constructs strategic networks, and the like. The development function includes the formulation of organizational development policy, the provision of career paths, and the determination of training policy, among others. The management function involves the appointment and assignment of personnel, the management of remuneration, promotion, retirement benefits, work conditions, labor management relations, education, and the human resource database, the evaluation of the target achievement levels, and monitoring activities.

b) EPF [217]

This is known as “Kumpulan Wang Simpanan Pekerja” (KWSP) in Malays. Established in 1951, the EPF has been operating a retirement benefit scheme under the EPF (Preliminary) Rules 1969 and now under the Employees Provident Fund Act 1991 (Act 452) (EPF Act 1991).

This EPF scheme is a compulsory funding scheme in which employees and employers contribute a prescribed portion of wages and in which employees receive benefits when retiring. The EPF falls under the Ministry of Finance.

c) Social Security Organisation (SOCSO) [218]

This is referred to as “Pertubuhan Keselamatan Sosial” (PERKESO) in Malay. SOCSO is in charge of a social insurance scheme in the private sector covering workers’ compensation, disability, and bereaved families. This system provides social security by providing health care services, adaptive equipment, and cash benefits, and the like, in the event that a work-related accident occurs or if an employee becomes disabled, thereby reducing the burden and anxiety of the employee and their family. SOCSO was established under the Employees' Social Security Act 1969 and the Employees' Social Security (General) Regulations 1971 as a subsidiary organization of the MOHR.

[217] Additions and modifications were made to JICA (2012), Malaysia,” in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-5 (5).
[218] Additions and modifications were made to JICA (2012), Malaysia,” in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-5 (6).

(3) Major Schemes [219]

Table 4-8 Types and summaries of pension and other income security schemes

System	GP	SOCSO	EPF
Target	government officer	Employees for Private companies	Employees for Private companies
Benefit scheme	Gratuity, pension, medical benefit, derivative benefit etc.for government officers	Employment Injury Scheme/ Invalidity Pension Scheme	Saving for the aged, withdrawals for the purpose of medical treatment, disability, housing, education , etc.
Administration organization	JPA	SOCSO	EPF

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the materials provided by JPA, EPF and SOCSO.

1) Government Pension (GP) [220]

a) Legal basis

From the viewpoint of securing capable human resources, the Government Pension scheme has been administered by the JPA under the Pension Act 1980, and other related laws. The pension scheme was revised under Act 662 (Retirement Fund ACT 2007) and Act 238 (Pension Adjustment Act 1980).

b) Benefit packages

In the case of death on duty or after retirement, this system provides a lump-sum distribution or monthly allowance. This system also provides the cash benefit according to the number of non-exercised paid vacation days. In addition, when a person entitled to receive pension dies, this system provides pension for the widow and the unmarried children under the age of 21.

The medical benefits of this scheme are available not only to government officers but also to their spouses and unmarried children (up to 21 years of age), who can receive most health care services free of charge. Medical benefits are provided even after government officers retire from service. As for the officers themselves, medical benefits cover expensive care for

[219] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report,* p. IV-16(5).
[220] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*,pp. IV-16 -19.

specific diseases. Starting from May 2011, government officers who chose to join the EPF are also entitled to a similar medical benefits. [221]

c) Eligibility for enrollment

Government officers are eligible for the government pension, including teachers, judges, federal officers, state government officers, railway officers, and police officers, and others in public service.

Military personnel, who are eligible for another pension scheme, are treated as government officers and join GP when they are promoted to captain or higher. When they become treated as government officers, pension portability is allowed and they can carry over the contributions that they have paid.

Among those eligible for GP, the government officers, and other civil servants, employed after the revision of the act in 1991 and 1992 (Act A793 and Act A823) can choose either the EPF or the pension scheme for the public sector as a result of the revision (Section 6A). However, the pension scheme for the public sector is definitely more favorable than the pension provided by the EPF. Therefore only a few officers are actually expected to choose the EPF. [222]

d) Contribution rates

The public institutions that employ the beneficiaries contribute 17.5% of their salaries (Section 12 B).

e) Funds and operational bodies

GP is operated by the JPA and funded by the federal government (appropriated from the national budget, including taxes). The retirement benefit is to be ultimately taken over by the retirement allowance fund.

[221] According to the person in charge at the JPA, the introduction of a hybrid scheme combining the public and private insurance is being considered.

[222] Sugaya, Hironobu (2012), *Old Age Income Security System in Malaysia* by Hironobu Sugaya (2012) (Japanese).

Table 4-9 Breakdown of pension enrollment and beneficiaries

(as of February 2012)

Category of pensioner and pension recipients	Total pensioner and Pension recipients
Federal public service	343,561
State public service	68,386
Statutory authority	87,886
Local authority	27,726
Members of parliament & Members of federal administration	1,038
Political secretaries	130
Judges	90
	528,817

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the materials provided by JPA

Source: Public Service Department Malaysia, Overview of Pensions Policy in Malaysia

Figure 4-6 Changes in the amount allocated to the JPA and benefit payments

In the public sector, employees are entitled to receive a retirement pension equal to 20–60% of the last pay drawn, according to the length of service. A sliding pay scale system has been in use since 1981. The basic calculation formula is 1/600 x the months served x the last pay drawn. The number of months served is limited to a maximum of 360 months. As a retirement allowance, 7.5% of the amount calculated by multiplying the last pay drawn and the number of months served is paid (Pension Regulation 1980 Sec.4). The pension is paid to those who retired for the reasons listed below (Section 10–Section 12A).

Table 4-10 Eligible reasons of retirement for pension benefits

∗ Attaining age of 60(effective from January 2012) ∗ Health reasons ∗ Abolition of office ∗ Reorganization of department ∗ Obtaining foreign citizenship (whether it is a government system does not matter) ∗ Optional retirement (upon attaining age of 40) ∗ In the case of transfer to other organizations with officer's agreement (whether it is a government system does not matter)

Source: Compiled by Mitsubishi UFJ Research & Consulting based on Malaysian Government, Pension Regulation 1980 Sec.4.

In the case of optional early retirement, the pension benefit commences at the age of 45 or 50. The commencement age of 45 applies to female employees, firefighters, police officers and prison officers below a certain rank, and male nurses at mental hospitals, and the commencement age of 50 applies to male employees other than those mentioned above. In the case of transfer to other organizations, [223] the pension benefits commence when the employee reaches the age of 50 for male and 45 for female, if the transfer takes place before the employee reaches that age, and it commences when the employee reaches the age of 55 if the transfer takes place before the employee reaches the above specified age. If an employee dies before reaching these ages, a survivor's pension is paid. [224]

Since the current tax-based pay-as-you-go system entails a heavy financial burden, the JPA intends to make a shift to a defined contribution scheme from a sustainability perspective.

[223] Transfer to other organizations (whether it is a government subsidiary or not) with the consent of the government

[224] According to *Old Age Income Security System in Malaysia* by Hironobu Sugaya (2012) (Japanese)

Table 4-11 Benefit packages of the GP scheme

	Benefit packages	remarks
1)Retirement benefits Gratuity (lump sum)	7.5%×months of reckonable service (month)×last drawn salary	＊w.e.f:1 st January 2009 (i.e. maximum at 30 years (360 months) of service)
2)Retirement benefits Pension (monthly)	1/600×months of reckonable service×last drawn salary (but not more than three- fifths of last drawn salary)	＊w.e.f:1 st January 2009(i.e. maximum at 30 years (360 months) of service)
3)Cash in lieu of leave	1/30×up to a maximum of 150 days of vacation leave not taken due to exigencies of service × total monthly emolument	＊ Total monthly emolument includes salary and fixed allowances.
4)Medical benefits	Free or subsidized medical benefits: ・Specified medical treatment and medication without charge for pensioner, spouse and minor children available at government hospitals and clinics. ・ Medical treatment in private hospitals and medication purchased from private providers/suppliers not available from government hospitals upon recommendation/ prescription by Government medical officers. ・Medical treatment overseas upon recommendation by government medical officers and decision by Board of Officers.	
5)Derivative benefits	・If the government officer dies in service, the bereaved families can receive retirement allowance, survivor's pension, and medical benefits. ・ Regarding to the retirement allowance, his (her) parents can receive allowance as well as widow(er) and children. ・Even if member himself(or herself) dies after retirement, the bereaved families can receive survivor's pension and medical benefit.	
6)Disability/Dependent's pension	・ Paid in addition to pensions/derivative pensions. ・ When retirement or death is caused by -injury due to a mishap in the	

	Benefit packages	remarks
	performance of official duty or from a disease contracted in the line of duty or due to a travel accident but not resulting from the personnel's carelessness or wrongdoing, not the injury or disease aggravated by the personnel.	

Source: Public Service Department Malaysia, *Overview of Pensions Policy in Malaysia*

Table 4-12 Breakdown of the amount allocated to the JPA and benefit payments (2011)

	the amount allocated to the JPA		Benefit payments	
	Amount (MYR)	(%)	Amount (MYR)	(%)
Cash in lieu of leave	263,760,800	2.3	262,165,698	2.3
Compensation	—	0.0	—	0.0
Pension	8497,155,900	74.4	8494,017,149	74.5
Gratuity	2653,262,900	23.2	2643,613,695	23.2
Allowance	2,861,700	0.03	2,834,368	0.00
Total	11,417,041,300	100.0	11,402,630,911	100.0

Source: Public Service Department Malaysia, *Overview of Pensions Policy in Malaysia*

2) Employee Provident Fund (EPF) [225]

a) Legal basis

The retirement benefit scheme is operated under EPF (Preliminary) Rules 1969 and the subsequently enacted EPF Act 1991—Employees Provident Fund Act 1991 (Act 452).

This is a compulsory contribution fund to which employees and employers contribute a prescribed percentage of salaries. Under this saving-type provident fund system, employees withdraw the saved amount upon retirement.

Members of the fund are mainly private-sector employees, and this includes those who have no eligibility for pension benefits of government officers described above. Government officers are allowed to depart from GP and join the EPF.

b) Benefit packages

Benefits are granted upon retirement or the inability to work. There are two types of individual savings accounts of members: Account I, which accounts for 70% in terms of the amount of contribution and dividend, and Account II, which accounts for 30%. Account I is used to prepare for retirement from which the entire balance of savings can be withdrawn

[225] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, pp. IV-20 -25.

when the member reaches the age of 55. Members are allowed to manage part of the balance themselves. From Account II, savings can be withdrawn for down payment for a home purchase or loan repayment, or for the purpose of paying for the education of dependent children or for medical expenses, and so on.

Table 4-13 Benefit packages of the EPF

Type of withdrawals	Packages
Retirement withdrawals	・Age　55 years withdrawal (1) Lump-sum (2) Monthly (3) Anytime and any amount (4) Combination
Pre-retirement withdrawals	・Age 50 years withdrawal ・Housing withdrawal ・Healthcare withdrawal ・Education withdrawal ・Members' investment choice
Other withdrawals	・Death withdrawal ・Incapacitation withdrawal ・Leaving the country ・Pensionable Employees Withdrawal ・Millionaire Withdrawal
Additional benefits	・Incapacitation benefit（MYR 5,000） ・Death benefit（MYR 2,500）

Source: Compiled based on the materials provided by EPF Malaysia

c) Withdrawal for the purpose of paying medical expenses

The system of withdrawal for the purpose of paying medical expenses was introduced in 1994. It covers medical expenses for the members and their spouse, parents (including parents-in-law, stepmother, and stepfather), children (including stepchildren and adopted children), and siblings. The disease must be specified in the application. Eligible disorders were expanded from 36 to 55 covering a wide range of disorders including cancer, cardiovascular system disorders, gastrointestinal and digestive system disorders, urogenital system disorders, blood system disorders, and mental disorders.

When selecting eligible disorders, advice from a doctor who is a board member and opinions from experts are sought. In addition, the Malaysia Medical Association (MMA) provides cooperation.

d) Eligibility for enrollment and contribution rates

It is compulsory for employees to join the EPF, and a voluntary system is applied to

workers in the informal sector [226], including the self-employed, agriculture and fishery workers and foreign employees, and similar occupations. Since their income is unstable and paid at various times, they pay the contributions on a voluntary basis on the condition that "at least MYR 50 must be paid at a time."

Formerly, those over 55 years of age pay the contributions on a voluntary basis. However, with the increase in those who continue working beyond the age of 55, it became compulsory for these people to pay the contributions in 2008, though the employee's share of the contribution rate is half of that for those under [55].

Table 4-14 Current contribution rates

Target		contribution percentage (%)		
age	Wage	employee	employer	Total
Above 55	Above MYR 5,000	5.5	6	11.5
	Below MYR 5,000	5.5	13	18.5
Below 55	Above MYR 5,000	11	12	23
	Below MYR 5,000	11	13	24

Source: Materials provided by EPF Malaysia; effective from January 2012

e) Funds and operational bodies

The board members of the EPF consist of a chairman, five government representatives (including deputy chairman), five representatives of the employees, three professional representatives including a doctor, and a CEO. The current chairman is Mr. Tan Sri Samsudin Osman.

The Investment Panel is composed of seven members: a chairman, a representative of the Ministry of Finance, a representative of the central bank, three professional representatives specialized in finance and investment, and a CEO. The Investment Panel is responsible for the investment and management of the fund.

The handling of the investment fund is provided for in Section 18 (2) of EPF ACT1991. It is stipulated that the investment fund shall be deposited in the specified financial institutions including Bank Negara Malaysia, and shall be invested in the shares of the companies listed on the stock exchange in Malaysia and the debentures of public companies, and so on.

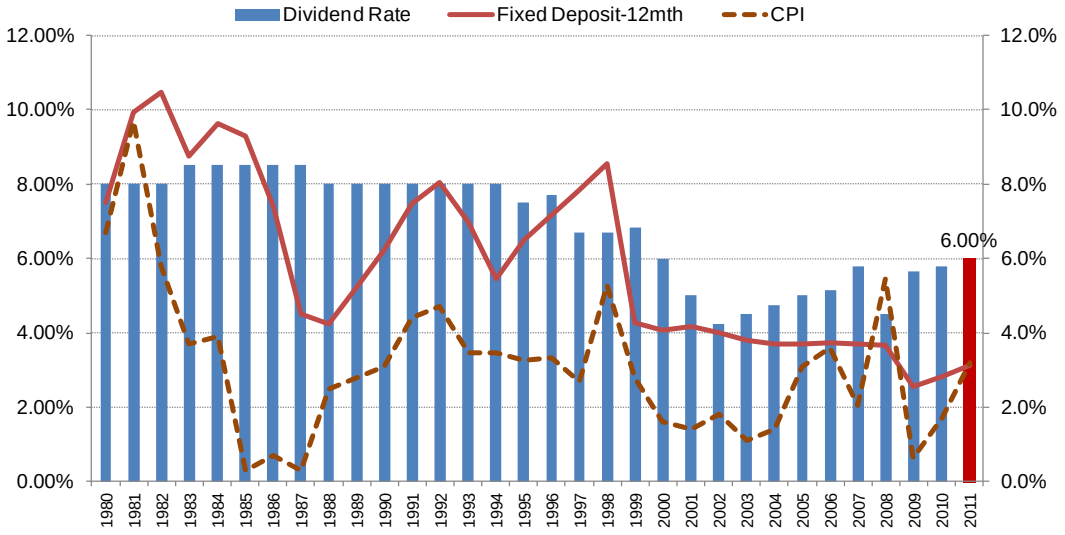
In member management, computerization has been going on since the 1980s. However, many members have not yet been familiarized with computers. The younger generations who can access the Internet are less interested in the balance of pension savings. Thus, the database system has not been fully utilized. [227]

[226] The informal sector defined by the EPF include the self-employed, agriculture and fishery workers, artists, specialist sole proprietors, household helpers, and those without a regular occupation, etc..
[227] According to an interview with the EPF.

Table 4-15 Changes in annual contributions to and withdrawals from the EPF

	2009		2010		2011	
	Billion MYR	Billion USD	Billion MYR	Billion MYR	Billion USD	Billion MYR
Annual contributions	33.47	11.10	35.76	11.86	41.43	13.74
Annual withdrawal	24.71	8.1	26.41	8.76	30.03	9.96
Accumulated asset	375.46	124.54	445.85	147.88	476.53	158.10
Investment income	17.26	7.72	24.41	8.10	27.24	9.04
Dividend rate		5.7%		5.8%		6.0%

Source: Materials provided by EPF Malaysia



Source: Materials provided by EPF Malaysia.

Figure 4-7 Changes in the EPF's dividend rate

f) Enrollment figures

As of 2011, a total of 13.14 million members are enrolled. Among them, those who are paying contributions ("Active Members") account for only about half of the total, or slightly above 6.26 million. Other members are retirees or those who have their own accounts but are currently not accumulating savings due to unemployment.

Since 2010, the enrollment of eligible informal sector workers has been promoted. As of the end of 2011, 48,452 informal sector members have enrolled. Under the slogan "1 Malaysia[228] Retirement Saving Scheme (SP1M)," the EPF established a voluntary savings

[228] "1 Malaysia" is the slogan set forth by Prime Minister Najib with the hope that Malaysia as a multi-ethnic nation will "unite and develop" to achieve the goal of joining advanced countries by 2020.

system for informal sector workers. The minimum contribution is MYR 50 at a time, and contributions may be paid at any time and frequency. The advantages of membership include entitlement to the dividend payment at a rate of 2.5% per annum, the death grant of MYR 2,500, and a tax credit of up to MYR 6,000 a year (for life insurance). Members can also receive incentives such as a matching contribution, which is a system where 5% of the government expenditures is credited to Account I with the upper limit of MYR 60 (2010–2014).

The EPF is seeking to grasp the number of eligible people in the informal sector. In addition, as the databases of the member information are not linked, the EPF is planning to integrate the databases into one, obtain data on eligible people in the informal sector, estimate the funds necessary for post-retirement life, and consider how to contribute the funds. [229]

Table 4-16 Breakdown of members in the informal sector (2011)

	(%)	Number of members
Housewives	16.76	8,120
Agriculture and fishing	6.25	3,028
Professionals agents, direct sellers artists etc.	6.51	3,154
Pensionable employees	2.48	1,202
Services and transportation	6.92	3,353
Business	34.84	16,881
Others	26.24	12,714

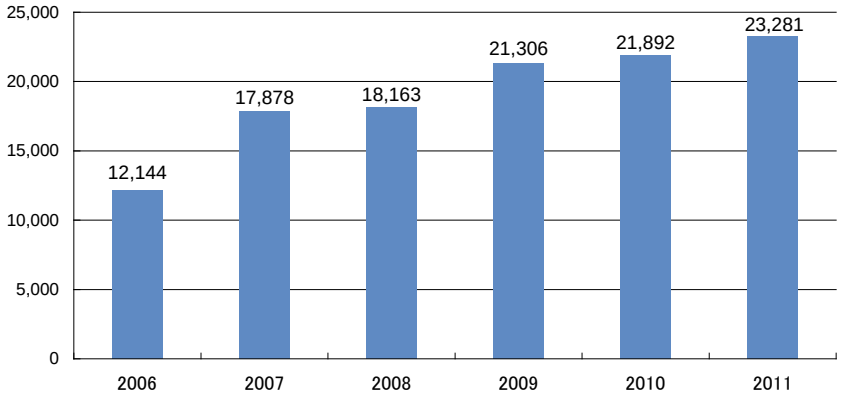
Source: Materials provided by EPF Malaysia

For the future, the EPF has set the goals of: 1) setting upper-limit wages that are to be against the contribution amount, and 2) realizing a compulsory contribution system for all employees and, for that purpose, collecting contributions along with the contributions to SOCSO and the health insurance by the MOH.

g) Actual benefit payments

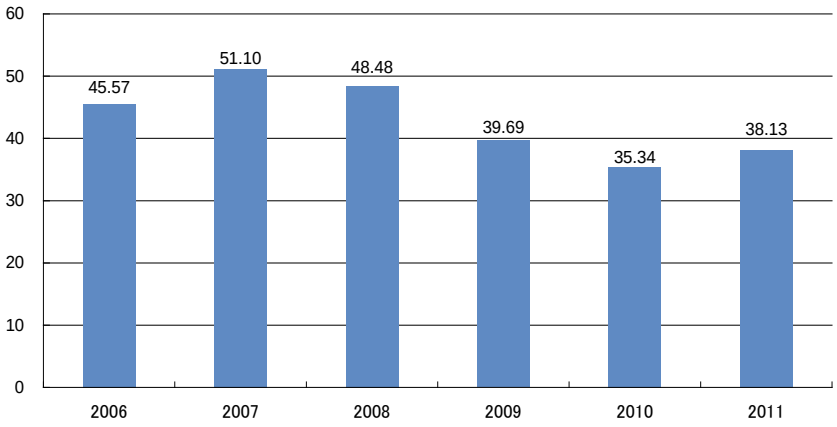
The annual total withdrawals have been increasing, while the amount withdrawn for the purpose of paying medical expenses has been decreasing since 2009. By method of withdrawal at the age of 55, the ratio of lump sum withdrawals is on the decrease, while that of monthly or partial withdrawal or a combination thereof is on the increase.

[229] According to an interview with the EPF



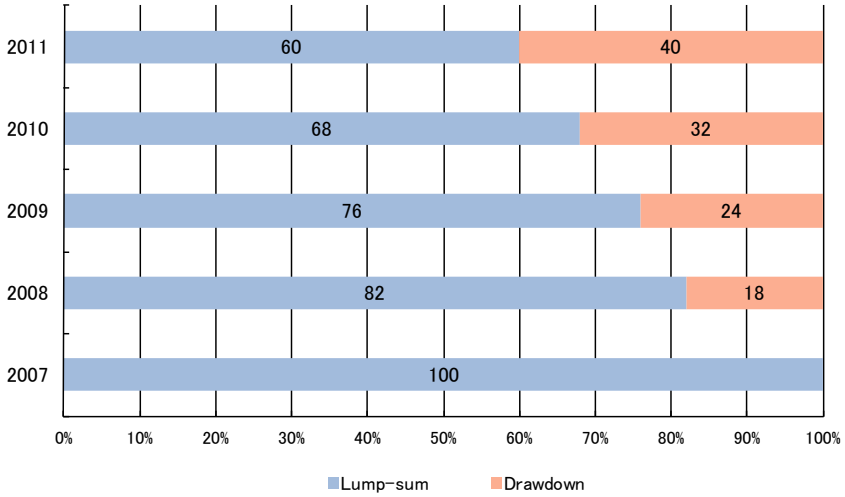
Source: Materials provided by EPF Malaysia

Figure 4-8 Withdrawals from the EPF for the purpose of paying medical expenses (Million MYR)



*Amount approved on applications for annual medical benefits
Source: Materials provided by EPF Malaysia

Figure 4-9 Withdrawals from the EPF for the purpose of paying medical expenses (Million MYR)



※"Drawdown" includes "Monthly", "Partial" and "Combination of monthly & partial".
Source: Materials provided by EPF Malaysia

Figure 4-10 Changes in the method of withdrawal at the age of 55 (%)

Table 4-17 EPF operational locations by function

Type of branches	Functions	Total
Type1	Receipting, Services and Enforcement	15
Type2	Services and Enforcement	30
Type3	Receipting and Services	1
Type4	Services only	17
Type5	Enforcement only	3
Total		66

Source: Materials provided by EPF Malaysia

3) Social security system for employees: Social Security Organisation (SOCSO) [230]

a) Outline of SOCSO [231]

The Social Security Organisation (SOCSO, or PERKESO in Malay) is an extra-governmental organization under the jurisdiction of the MOHR. It was established in 1971 as the Social Security Department of the government under the Employees' Social Security Act, enacted in 1969. It aims to provide work-related accident compensation and now functions as a provider of accident compensation, invalidity pension funds, and

[230] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-25-28.

[231] http://www.malaysia.gov.my/EN/Relevant%20Topics/Employment%20and%20Training/Citizen/EmployeeBenefitsContributions/Pages/EmployeeBenefitContributions.aspx

educational loan benefits. At present, its fund stands at MYR 18–19 billion (approximately 6 billion U.S. dollars).

Regarding invalidity pension scheme, SOCSO provides financial support to low-income employees whose income decreases due to total disability or incurable disease, even if not caused by a work-related accident.[232] However, this support amounting to MYR 300 per month is not enough to support their living and only plays a supplementary role.

b) Schemes of SOCSO

Under the labor laws, companies with one or more employees are obliged to join SOCSO at the time of business registration. As of the end of 2010, the number of effective employees who pay contributions at least once a month is about 5.52 million people, which accounts for approximately 44.2% of the working population of 12.5 million, and the number of effective employers is 348,000 companies.[233]

It is compulsory for employees who earn less than MYR 3,000 and their employers to join SOCSO, while self-employed people, foreign employees, and some others, are not eligible. Employees who earn over MYR 3,000 join SOCSO on a voluntary basis based on agreement with their employers. If the monthly wage of an employee exceeds MYR 3,000 after joining SOCSO, the employee is obliged to continue the payment of contributions.

SOCSO's schemes are classified into two categories according to the benefit packages. The first category covers the Employment Injury Insurance Scheme and the Invalidity Pension Scheme, to which employees under 55 years of age pay contributions jointly with their employers. The second category covers the Employment Injury Insurance Scheme only, and contributions are paid by employers only—not by employees. This category applies to employees aged 56 or older, those who joined SOCSO for the first time after reaching 50 years of age, or those whose income has been reduced to one-third due to employment injuries.

Employees who earn over MYR 3,000 per month and who have never joined SOCSO, government officers, household employees (including cooks, gardeners, household helpers or housekeepers, security guards, and drivers), the self-employed, and foreign employees are not eligible for these schemes.

[232] SOCSO employer's Guide, Ministry of Health, Labour and Welfare of Japan Reporting foreign affairs 2009-2010. It is necessary to satisfy the requirements such as examination of Medical Board examination.
[233] SOCSO *Annual Report 2010*

Table 4-18 SOCSO's schemes and eligibility

category	Scheme	eligibility	Contribution
First category	Employment Injury Scheme And Invalidity Pension Scheme	For employees below 55 years of age.	The contribution is paid by both the employer and employee.
Second category	Employment Injury Scheme only	・For employees above 55 years of age and still working. ・For employees above 50 years of age when first registered and contributed to SOCSO. ・For an Insured Person receiving Invalidity Pension who is still working and receiving wages which is less than 1/3 of the average monthly wage before invalidity.	The contribution is paid by the employer only.

Source: Compiled based on the website of SOCSO [234]

c) Contributions

The amount of contributions is determined based on the monthly wage of the employee. The monthly wage for this purpose includes the base pay, overtime pay, fees, and various allowances, such as the allowance for working on a holiday, housing allowances, and incentives, and other allowances. The annual total of the contribution payments has been increasing in the last three years.

[234] http://www.perkeso.gov.my/en/socso-contribution1.html

Table 4-19 SOCSO contributions

	First category (Employment Injury Scheme And Invalidity Pension Scheme)			Second category (Employment Injury Scheme)
Monthly wages(MYR) (Exceed-but not exceed)	Employer's contribution (MYR)	Employee's contribution (MYR)	Total contribution (MYR)	Total contribution by Employer only (MYR)
30	0.40	0.10	0.50	0.30
30-50	0.70	0.20	0.90	0.50
50-70	1.10	0.30	1.40	0.80
70-100	1.50	0.40	1.90	1.10
100-140	2.10	0.60	2.70	1.50
140-200	2.95	0.85	3.80	2.10
200-300	4.35	1.25	5.60	3.10
300-400	6.15	1.75	7.90	4.40
400-500	7.85	2.25	10.10	5.60
500-600	9.65	2.75	12.40	6.90
600-700	11.35	3.25	14.60	8.10
700-800	13.15	3.75	16.90	9.40
800-900	14.85	4.25	19.10	10.60
900-1,000	16.65	4.75	21.40	11.90
1,000-1,100	18.35	5.25	23.60	13.10
1,100-1,200	20.15	5.75	25.90	14.40
1,200-1,300	21.85	6.25	28.10	15.60
1,300-1,400	23.65	6.75	30.40	16.90
1,400-1,500	25.35	7.25	32.60	18.10
1,500-1,600	27.15	7.75	34.90	19.40
1,600-1,700	28.85	8.25	37.10	20.60
1,700-1,800	30.65	8.75	39.40	21.90
1,800-1,900	32.35	9.25	41.60	23.10
1,900-2,000	34.15	9.75	43.90	24.40
2,000-2,100	35.85	10.25	14.10	25.60
2,100-2,200	37.65	10.75	48.40	26.90
2,300-2,400	39.35	11.25	50.60	28.10
2,400-2,500	41.15	11.75	52.90	29.40
2,500-2,600	42.85	12.25	55.10	30.60
2,600-2,700	46.35	13.25	57.40	31.90
2,700-2,800	48.15	13.75	59.60	33.10
2,800-2,900	49.85	14.25	64.10	34.40
2,900 以上	52.65	14.75	66.40	35.60

Source: Compiled based on the SOCSO *Employers Guide*

Table 4-20 Changes in enrollment in SOCSO

year	Employer		Employee		Annual contributions (million MYR)
	Registered ('000)	Active ('000)	Registered ('000)	Active ('000)	
2008	684	389	12,603	5,670	1,834.66
2009	724	327	13,278	5,311	1,867.16
2010	770	348	13,832	5,519	2,007.87

Note 1: The number of registered companies (employees) shows the number of members registered since the establishment of SOCSO.
Note 2: The number of effective companies (employees) shows the number of employers or employees who pay contributions at least once a month.
Source: Compiled based on the SOCSO *Annual Report 2010*

d) Issues for the future

While there has been a discussion of raising the retirement age, the retirement age for government officers has already been raised from 55 to 60. The intention is to, by extending the service years of the elderly, help increase savings and reduce the unwaged period from retirement to the end of life. The government recommends that the private sector adopt the same policy.

When an employee becomes unemployed due to a work-related injury, or some other reason, income security is provided through SOCSO. Therefore, some believe that SOCSO should also assume the function of unemployment insurance. However, this is not easy because the systems are different.

4) Public assistance for the elderly [235]

Financial assistance is provided to the low-income elderly so that they can continue living in their home and community. Financial assistance of MYR 300 a month is provided to eligible elderly persons who are aged 60 or older with no regular income and who have no relatives or family who assist them. For the elderly who cannot afford to buy welfare equipment or supportive devices, financial assistance is provided to cover the purchase price, subject to recommendation by the person in charge of medical care.

[235] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-33.

(4) Major Issues

1) Issues surrounding employee social security [236]

The EPF does not have sufficient funds, as the members paying contribution account for less than half of all members enrolled and as its savings are not enough to cover the money necessary for post-retirement life. Therefore, the system of the EPF needs to be strengthened through an increase in the contribution rate of employees, and other mechanisms. [237] As most of the member of the EPF run out of their savings within 5 years after they become qualified age, savings of the EPF is not sufficient for income security and covering the expenditures for care in the retirement age. [238]

Since enrollment in the EPF is voluntary for self-employed persons, informal sector workers including household helpers, and foreign employees, how to have these people enrolled is an issue to be addressed. Another issue is the absence of a system equivalent to the National Pension System of Japan.

As for GP, the current tax-based pay-as-you-go system carries a heavy financial burden, and the government intends to make a shift to a defined contribution scheme.

[236] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, p. IV-39(3).
[237] JETRO website.
http://www.jetro.go.jp/world/asia/my/biznews/4f5592bc96e10
[238] Masud and Haron (2012), "Gender Differences in Economic Status of Older Malaysians," p.68, 74.

5. Initiatives for the Living Environment

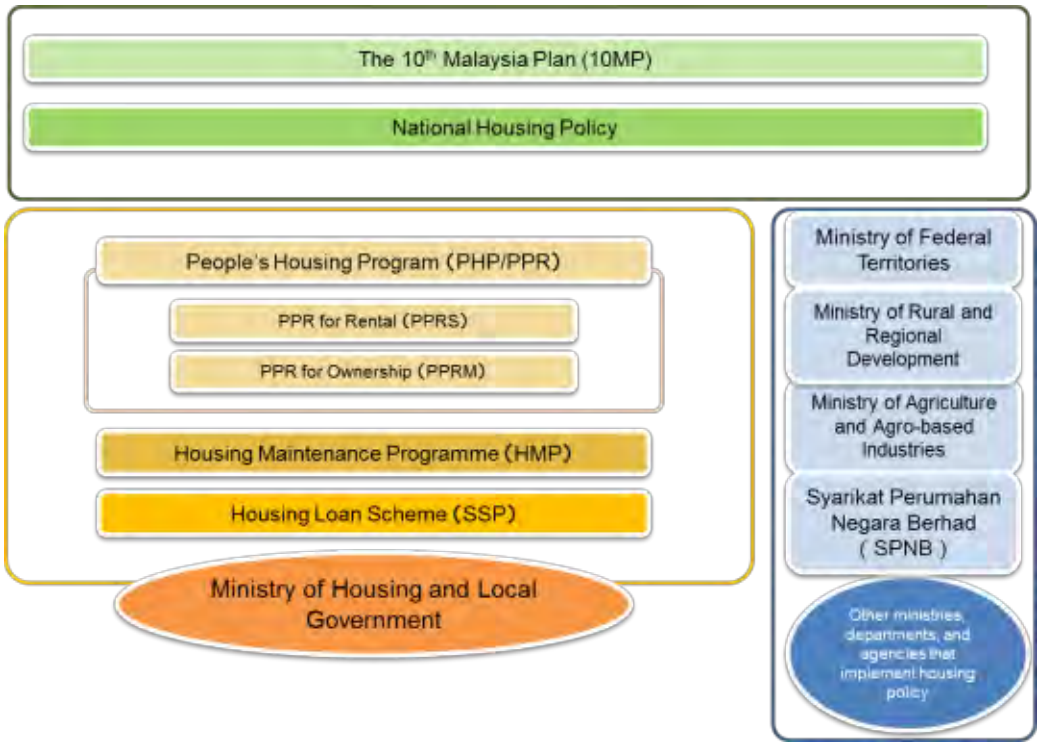
5.1. Outline

This chapter examines policies for the elderly related to the living environment, particularly matters involving housing policy and universal design policy. However, although we speak of policies for the elderly related to the living environment, as in other fields, the policies are of course not designed exclusively for the elderly. Rather, measures for the elderly are included among social security policies designed for the poor and PWDs. As described below, several of the housing policies for low-income earners are targeted at persons under the age of 60, so the measures for the poor and for the elderly are not completely identical.

Malaysia's housing policy is based on the idea of "provision of adequate, affordable, and quality housing for all Malaysians." Since Malaysia gained independence, the provision of low-cost housing has been a priority in the five-year plans. The specific policies being implemented include the People's Housing Programme, which provides housing for sale to squatters and low-income earners, and the Housing Maintenance Programme (HMP). Public housing policy is primarily handled by the Ministry of Housing and Local Government, but the Ministry of Rural and Regional Development, the Ministry of Federal Territories, and the Ministry of Agriculture and Agro-Based Industry, to name a few, implement their own housing support services. Thus, one of the issues affecting Malaysia's housing policy is the fact that multiple bodies provide redundant services.

Guidelines for public facilities and universal design are drawn up by the Town and Country Planning Department (FDTCP) in the Ministry of Housing and Local Government. The FDTCP has drawn up Planning Guidelines for Community Facilities (GP004-A) and Planning Guidelines for Universal Design (GP015-A). Both are comprehensive guidelines that include PWDs, not guidelines dedicated exclusively to the elderly. The government is not actively engaged in implementing PWD policies although a comprehensive PWD Act was passed in 2008. Besides, the 10MP aims to support social participation and independence of people with disabilities (See 2.1.(1)). However, some knowledgeable people have pointed out that, although a law and guidelines exist for universal design, implementation has delayed.

Next, following a general survey of living environment policies, we describe housing policies and universal design policies, and finally, we point out some relevant issues.



Source: Prepared by MURC from various materials.

Figure 5-1 Overview of Housing Policies for Low-income Earners

5.2. Main Bodies and Organizations (public bodies, companies, NGOs, etc.)

(1) Roles and Functions of Main Bodies

1) Ministry of Housing and Local Government

The Ministry of Housing and Local Government was first established in 1964 as the Ministry of Local Government and Housing.[239] In 1978, it assumed its current name after merging with the Ministry of Housing and Rural Development and the Department of Local Government in the Ministry of Local Government and the Federal Territory.

The Ministry of Housing and Rural Development has the following five objectives:[240]

- To prepare and implement a comprehensive and unified rural and urban plan to strengthen environmentally-friendly development physically, socially, and economically.
- To encourage, development, and guide local authorities so they can provide high-quality urban, social, and recreational services and can provide opportunities for unified economic growth.

[239] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/325(accessed 27 June, 2013)
[240] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/325(accessed 27 June, 2013)

- To ensure the development of housing that is comfortable and fully equipped with social and recreational amenities in a balanced manner.
- To guarantee the safety of life and possessions through preventative and supervisory services for fires and dangerous materials, efficient and effective crisis rescue services, and provision of information and education on fire and fire prevention.
- To achieve the goal of making Malaysia a garden nation by developing natural scenery, parks, and high-quality recreational facilities.

The role of the Ministry of Housing and Local Government encompasses the following seven items: [241]

- Provide affordable housing and regulation of housing development.
- Support and guide local governments so they can provide high-quality local services and social and recreational amenities.
- Provide preventative, firefighting, and rescue services.
- Provide suggestions to the federal and state governments concerning planning, management, development, and soil conservation.
- Provide policy and advising services to local governments and government agencies for planning, implementation, and management of natural scenery, parks, and recreational facilities.
- Implement policies, regulations, and management for waste disposal and public sanitation that are integrated, efficient, reliable, and cost-effective.
- Develop and regulate consumer loan businesses and pawnshops.

2) Ministry of Rural and Regional Development [242]

The Ministry of Rural and Regional Development has jurisdiction over policies for rural and regional development. It advances various goals for rural and regional development. Specifically, the goals to be reached by 2020 include raising the income of rural people to 80% of that of urban dwellers, improving the welfare in rural areas, expansion of coverage of basic infrastructure and public facilities, mitigation of hardcore poverty, and lowering the poverty rate to 2.8%.

3) Ministry of Federal Territories

The Ministry of Federal Territories was established in 1979. Its role was to coordinate the

[241] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/325 (accessed 27 June, 2013)
[242] Ministry of Rural and Regional Development website http://www.rurallink.gov.my/web/guest/objektif (accessed 11 September, 2013)

development of Kuala Lumpur and Klang Valley.[243] In the Cabinet reshuffling in 2004, the ministry was tasked also with the development of federal territory (Kuala Lumpur, Labuan, and Putrajaya) in addition to development coordination for the Klang Valley. In 2009, it was renamed the Ministry of Federal Territories and Urban Wellbeing, and eradication of urban poverty and implementation of urban welfare programs were added to its duties. In May 2013, when the roles of poverty eradication and welfare programs were returned to the Ministry of Housing and Local Government, this ministry once again was dedicated exclusively to the development of federal territories, and its name reverted to Ministry of Federal Territories.

Policies being pursued for the development of federal territories include the ICT Security Policy and the Affordable Home Policy of Federal Territories.[244]

4) Ministry of Agriculture and Agro-Based Industry

The Ministry of Agriculture and Agro-Based Industry does research and development (R&D) on the preparation and implementation of agricultural policies and strategies, improvement of productivity, and boosting of competitiveness in the agricultural sector. The ministry also is responsible for promoting agricultural investment.[245] In 1955, the Ministry of Agriculture was established, and the current name, Ministry of Agriculture and Agro-Based Industry, was adopted in 2009.[246]

5) Syarikat Perumahan Negara Berhad (SPNB)

Syarikat Perumahan Negara Berhad (SPNB) is a subsidiary wholly owned by the Ministry of Finance. It was established in 1997 for the purpose of providing high-quality, affordable housing for all households, based on the national housing policy objectives.[247] It is the implementer of the Rumah Mampu Milik Programme, which is an affordable housing program with the goal of securing affordable housing for the low-income group, and the Rumah Mesra Rakyat Programme. Moreover, the SPNB also implements the Rehabilitation of Abandoned Housing Projects, the People's Housing Program (PPR), and a program to provide tsunami victims with housing.

---

[243] Ministry of Federal Territories website
http://www.kwp.gov.my/index.php?option=com_content&view=article&id=19&Itemid=60&lang=en (accessed 11 September, 2013)
[244] Ministry of Federal Territories website
http://www.kwp.gov.my/index.php?option=com_content&view=article&id=54&Itemid=89&lang=en (accessed 11 September, 2013)
[245] Ministry of Agriculture and Agro-Based Industry website
http://www.moa.gov.my/web/guest/fungsi (accessed 13 September, 2013)
[246] Ministry of Agriculture and Agro-Based Industry website
http://www.moa.gov.my/web/guest/sejarah (accessed 13 September, 2013)
[247] SPNB website
http://www.spnb.com.my/eng/corporate/corporate.htm (accessed 13 September, 2013)

(2) Division of Roles between Public Bodies and the Private Sector, such as Companies and NGOs

As shown by the fact that more than half of the affordable housing that is low-cost housing and above is constructed by the private sector (see Figure 5-2 below), the private sector plays a large role in supplying low-cost housing, excluding housing for the poor.

The 10th Malaysia Plan sets forth the implementation of affordable housing programs in urban areas and the expansion of the supply of low-cost housing, but private companies are expected to play a role here as well, and are particularly needed to supply affordable medium-cost housing. [248]

5.3. Main Services and Support

(1) The Malaysia Plan

Malaysia's housing policy is based on the idea of "provision of adequate, affordable, and quality housing for all Malaysians." Since Malaysia gained independence, the provision of low-cost housing has been a priority in the five-year plans. [249]

Since the 7th Malaysia Plan (1996-2000), the Malaysian government has put more energy into low medium housing than it had previously. [250] Of the new housing being constructed, this plan aimed to build 350,000 units of low medium housing. However, while construction of medium-cost housing and high-cost housing did progress, construction of low medium housing did not meet the target.

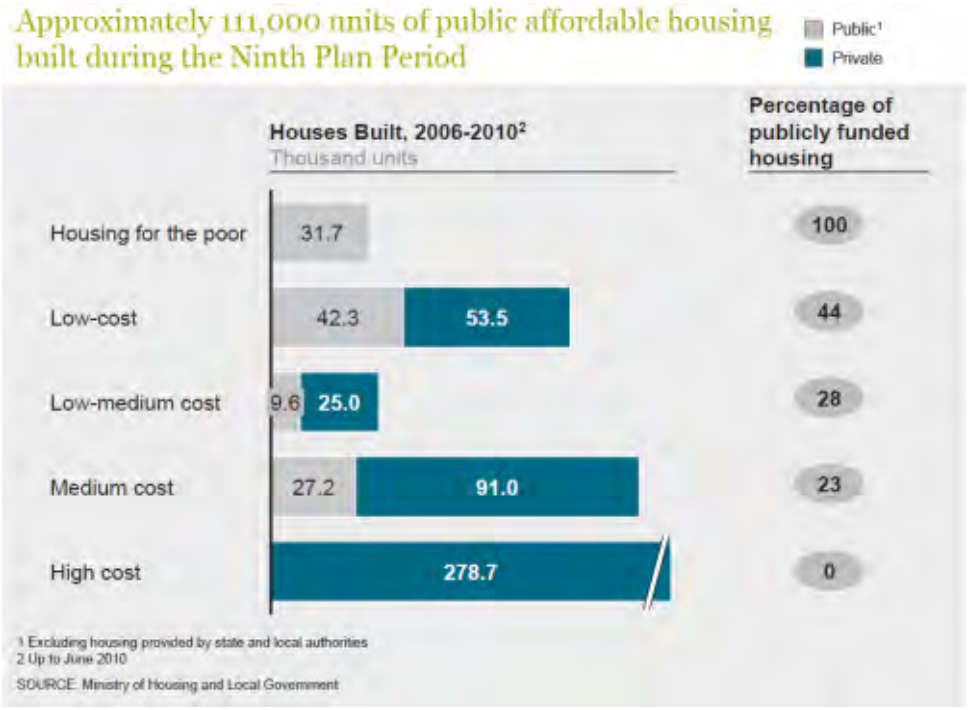
Under the 9th Malaysia Plan, approximately 560,000 housing units were constructed, and of those, 31,700 units were for the poor, 95,800 units were low-cost housing, 34,600 units were low medium housing, and 118,200 units were medium-cost housing. All the housing for the poor is public housing, while public housing constitutes 44% of the low-cost housing, 28% of low medium housing, and 23% of medium-cost housing. With regard to the number of new housing starts, the figure for high-cost housing is the largest of all categories, at 278,700 units. The next largest is medium-cost housing, showing that more housing in the higher price range is being constructed than low-cost housing. Even so, the lack of affordable housing is no longer a problem in the 10th Malaysia Plan, but rather the issue is supplying adequate housing to various regions. [251]

---

[248] Tenth Malaysia Plan, p.160.
[249] Shuid, Syafiee (2003). *Low Medium Cost Housing in Malaysia: Issues and Challenges*, p.2.
[250] Bakhtyar, B., A. Zaharim, K. Sopian, and S. Moghimi (2013). "Housing for Poor People: A Review on Low Cost Housing Process in Malaysia," *WSEAS Transactions on Environment and Development*, Issue 2, Volume 9, p.128.
[251] Tenth Malaysia Plan, p.277.

The only housing for the poor is public housing, but when it comes to low-cost, low medium, and medium-cost housing, the majority of the units are built by the private sector. So, it can be seen that, even if the housing is for low-income earners, the role played by the private sector is large. This trend is not limited to the period of the 9th Malaysia Plan. Since the 1990s, a phenomenon has been visible in which housing in the higher price ranges has better achieved the planned ratio, [252] and even when it comes to housing the lower price ranges, the private sector has supplied a large amount. [253]

Furthermore, from 1990 to 2009, 808,000 low-cost housing units were constructed. [254]



Source: Tenth Malaysia Plan, p.277.

Figure 5-2 Affordable Housing Constructed during the 9th Malaysia Plan

In the 10th Malaysia Plan, the housing problem is covered in Chapter 4, Comprehensive Social and Economic Development, and Chapter 6, Construction of an Environment to Improve the Quality of Life.

Chapter 4 discusses construction and upgrading of housing in regional areas for households with a large number of members, elderly persons, single parents, and people with special

[252] In the 6th Malaysia Plan, the goal for new construction of low-cost public housing was 126,800 units, but the actual figure was 46,497 units, or 36.7% of the goal. Meanwhile, medium-cost public housing achieved 78.9% of its goal, and high-cost public housing achieved 109.6% of its goal. In the 7th Malaysia Plan, the goal for new construction of hardcore poor housing was 35,000 units, but the actual figure was 17,229 units, or 42.9% of the goal. Low-cost public housing achieved 101.7% of its goal. Medium-cost public housing achieved 108.7% of its goal, and high-cost public housing achieved 57.3% of its goal.
Shuid, Syafiee (2003). *Low Medium Cost Housing in Malaysia: Issues and Challenges*, p.6.

[253] Shuid, Syafiee (2003). *Low Medium Cost Housing in Malaysia: Issues and Challenges*, p.6.

[254] Tenth Malaysia Plan, p.277.

needs.[255] They need to be provided with housing not only through government assistance but also through GLC and private companies' CSR.

In urban areas, the government is implementing an affordable housing programme and expansion of the supply of low-cost housing.[256] It is to be borne in mind that these kinds of public housing are provided to individuals and families in the lower 40% economically. Here as well, private companies are expected to play a role by providing medium-cost affordable housing.

Chapter 6 discusses the affordable housing policy. According to the 10th Malaysia Plan, the issues in Malaysia's housing policy are (1) matching of the housing demand with the supply based on the region and purchasing power, (2) improvement of the quality of new and existing affordable housing, and (3) response to demands for a sustainable environment.[257] To resolve these issues, the need for the following has been raised: (1) streamlining the housing supply system, (2) strengthening of efforts for a housing supply that is good quality and environmentally friendly, (3) nurturing a healthy and sustainable housing industry. For "(1) streamlining in the housing supply system," the following have been put forward: construction of 78,000 units of affordable housing, creation of a housing maintenance fund, and streamlining the numerous bodies that supply housing.[258]

The categories of housing cost are prescribed by the Ministry of Housing and Local Government. Below is the cost table prescribed by the Ministry of Housing and Local Government; it has not been revised since 1998.[259] Since land prices have been rising, the highest cost is scheduled to go up.[260]

The sale price of housing for low medium income earners is between 30% and 75% of the construction cost.[261] However, for the hardcore poor whose monthly income is around MYR1,000, this makes low-cost and low medium housing too expensive to purchase.[262]

---

[255] Tenth Malaysia Plan, p.160.
[256] Tenth Malaysia Plan, p.160.
[257] Tenth Malaysia Plan, pp.277-278.
[258] Tenth Malaysia Plan, p.277.
[259] Bakhtyar, B., A. Zaharim, K. Sopian, and S. Moghimi (2013). "Housing for Poor People: A Review on Low Cost Housing Process in Malaysia," *WSEAS Transactions on Environment and Development*, Issue 2, Volume 9, p.130.
[260] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[261] Tenth Malaysia Plan, p. 278, and On-site hearing survey on April 29, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[262] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).

Table 5-1 Housing Cost List

Category	Housing Cost per Unit	Target Group Income Level
Before 1998		
Low-cost housing	Up to MYR 25,000	Under MYR 750
Low medium housing	MYR 25,001-60,000	MYR 750-1,501
Medium cost housing	MYR 60,001-100,000	MYR 1,501-2,500
High-cost housing	MYR 100,001 and above	MYR 2,501 and above
After 1998		
Low-cost housing	Up to MYR 42,000	Up to MYR 1,500
Low medium housing	MYR 42,001-60,000	MYR 1,501-2,500
Medium cost housing	MYR 60,001-100,000	
High-cost housing	MYR 100,001	

Note: In the states of Sabah and Sarawak, developers can raise the sale price with 20% as the upper limit.
Source: Bakhtyar, B., A. Zaharim, K. Sopian, and S. Moghimi (2013). "Housing for Poor People: A Review on Low Cost Housing Process in Malaysia," WSEAS Transactions on Environment and Development, Issue 2, Volume 9, p.130.

(2) National Housing Policy

The Malaysian government drew up the National Housing Policy in 2011. The objective of the National Housing Policy is to supply adequate, comfortable, high-quality affordable housing to improve the welfare of people, and the policy indicates the direction of the plan and development for the housing sector. The following six objectives are the priority objectives of the National Housing Policy.

1. Supply adequate housing to people with special needs.
2. Improve the quality and productivity of housing development.
3. Improve the efficacy of implementation of the housing service supply system and ensure compliance.
4. Improve people's ability to acquire housing and ability to rent.
5. Ensure the sustainability of the housing sector.
6. Improve the level of social amenities, basic services, and liveability of environments.

The National Housing Policy mentions the housing problems of the elderly. A problem faced by the housing sector in Malaysia is that, while the housing provided by the private sector is adequate for the high-income earners, the housing is inadequate for low medium income earners, including people who require special care, the elderly, single mothers, and squatters. [263] Among the above-mentioned priority objectives, the one that particularly involves the elderly is the supply of housing for people who need special care. [264] The policy

[263] National Housing Policy, p.68.
[264] National Housing Policy, pp.82-83.

indicates that the government and the private sector will continue to endeavor to supply affordable housing for both purchase and rental for low-income earners, PWDs, the elderly, and single mothers. The private sector is called on to promote development of housing for medium-income earners with monthly incomes of MYR 2,500 to 3,999.

(3) Public Housing (rental and purchase)

1) People's Housing Programme (PHP/PPR) [265]

As stated above, one of the objectives of the Ministry of Housing and Rural Development is to guarantee the development of housing that is fully equipped with social and recreational amenities that are satisfactory and well balanced. To achieve this objective, the Malaysian government has implemented the People's Housing Programme. [266] The system was established in 1998 (and the PPRS mentioned below was introduced in 2002).

The People's Housing Programme assists with reestablishing squatters in a permanent residence and the necessary conditions for residence in housing for low-income earners. The programme is run by the National Housing Department in the Ministry of Housing and Local Government. The People's Housing Programme is subdivided into PPR for Rental (PPRS) and PPR for Ownership (PPRM). PPRM was initially available only in the state of Pahang, but starting from the 10th Malaysia plan, the eligible regions were expanded to Kelantan, Kuala Lumpur, and Sabah.

The price of housing in PPRM varies depending on the region, but it is MYR 30,000 to MYR 35,000 on the peninsula and MYR 40,500 in Sabah and Sarawak. Moreover, the monthly rental rate in PPRS is MYR 124.

The specifications for PPRM and PPRS housing are shown below. These specifications are prescribed by the National Housing Standard for Low Cost Housing Flats (CIS 2).

- Multi-story housing from 5 to 18 stories in major cities
- Land on the coast or suburbs (landed property)
- Square footage per unit over 700 square feet (approximately 65 sq. meters. Previously, the requirement was 600 sq. feet and then 650 sq. feet) [267]
- Three bedrooms, one living room, one kitchen, and two bathrooms

[265] People's Housing Programme (PHP). National Housing Department website http://ehome.kpkt.gov.my/en/main.php?Content=vertsections&SubVertSectionID=263&VertSectionID=17&CurLocation=91&IID=&Page=1(accessed 27 June, 2013)

[266] People's Housing Programme, Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_2013/program_kpkt/PPR_eng.pdf (accessed 26 June, 2013)

[267] People's Housing Programme, Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_2013/program_kpkt/PPR_eng.pdf (accessed June 26, 2013).

Almost all of the public housing provided by the Ministry of Housing and Local Government is condominium housing. The floor plans are as regulated above. However, because people's lifestyles are becoming more diversified in recent years, such as some with large families and some with two-person families, a study is underway on changing the floor plan to suit the household size. [268]

As of the end of 2011, for PPRS housing, there were 76,159 units being constructed in 88 projects. Of these, 64 projects had finished, and 62,716 units were completed. [269] For PPRM housing, there were 3,672 units being constructed in 27 projects (all in the state of Pahang). Of these, 22 projects had finished, and 3,062 units were completed. [270] The remaining projects are scheduled to finish during the 10th Malaysia Plan. The reason why the number of public housing units for sale is strikingly small compared to units for rent is that the policy for selling public housing began in 2011 and it has a short history. [271] In addition to these, the number of units scheduled for construction in the 10th Malaysia Plan in 1,000 units in Kelantan, 1,600 units in Kuala Lumpur, and 1,200 units in Sabah.

2) Housing Maintenance Programme (HMP) [272]

The Housing Maintenance Programme (HMP) is implemented by the National Housing Department of the Ministry of Housing and Local Government under the 10th Malaysia Plan. It provides subsidies for maintenance and repair of public and private low-cost housing. A budget of MYR500 million is to be allocated from 2011 through 2015. The recipients will include both public and private housing, with 90% of the expenses borne by the government and the remaining 10% borne by building management. [273] Conditions for applying to the HMP are as follow.

- The application is made by the building management of public and private low-cost housing.

[268] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[269] 64,777 units completed as of April 2013. On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[270] 3,109 units completed as of April 2013. On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[271] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[272] Housing Maintenance Programme (HMP). National Housing Department website http://ehome.kpkt.gov.my/en/main.php?Content=vertsections&SubVertSectionID=172&VertSectionID=17&CurLocation=91&IID=&Page=1 (accessed 27 June, 2013)
[273] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/361 (accessed 13 September, 2013)

- The “building management of public low-cost housing” refers to the state government or state government agency (including the states of Sabah and Sarawak). It does not include federal-owned housing.
- The “building management of private low-cost housing” refers to management agencies appointed by the Joint Management Body established under the Building and Common Property Act (Act 663 [2007]) or the management company or Commission of Building (COB) established under the Strata Titles Act (Act 318).

The following are objects of maintenance and repair:

- Repair, renovation, and replacement of 1) Elevators, 2) water tanks and pipes, 3) sewer pipes, 4) roofs, and (5) stairs and handrails.
- Painting and repainting of the buildings every 10 years.
- Repair, renovation, and replacement of equipment in common areas which may impair residents’ lives.

3) Housing Loan System [274]

The Housing Loan Scheme (SPP) is implemented though the Housing Loan Fund [275] which targets low-income earners. This system was introduced in 1976 based on the Financial Procedure Act 1957. [276] The purpose of the system is to provide funds to the low-income earner segment which is unable to access loans in order to enable the construction and purchase of housing. Its rolling capital is MYR 7, 000, and this is used to assist construction and purchase of housing by low-income earners. The upper limit on loans from SPP is MYR 45,000. Qualifications to receive a loan are as follow: [277]

- Malaysian citizen
- From 21 to 60 years old
- Not a government officer (and not the spouse of a government officer)
- Does not own one’s own residence
- Monthly household income from MYR 750 to MYR 2,500
- The loan recipient or a near relative (mother, father, sister, brother, spouse, uncle owns

[274] Housing Loan Scheme. National Housing Department. http://ehome.kpkt.gov.my/en/main.php?Content=vertsections&SubVertSectionID=98&VertSectionID=17&CurLocation=91&IID=&Page=1 (accessed 27 June, 2013)
[275] The Housing Loan Fund was established by the Financial Procedure Act 1957.
[276] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/360 (accessed 13 September, 2013)
[277] Ministry of Urban Wellbeing, Housing and Local Government website http://www.kpkt.gov.my/kpkt_bi_2013/index.php/pages/view/360 (accessed 13 September, 2013)

land

- Enrollment in guarantee insurance through panel insurance

(4) Rental Subsidy Scheme for the Hardcore Poor [278]

The Rental Subsidy Scheme was established for the hardcore poor who cannot even afford public housing for low-income earners. This scheme originally began under the Ministry of Housing and Local Government, but currently it is under the jurisdiction of the Ministry of Federal Territories. In this scheme, the rent of the hardcore poor who are registered in E-kasih is paid in part or in full by the Ministry of Federal Territories.

(5) Subsidies for Housing Construction and Maintenance from Ministries and Departments [279]

In Malaysia, various ministries and departments other than the Ministry of Housing and Local Government implement their own housing subsidy policies.

The Ministry of Rural and Regional Development provides an allowance for housing maintenance expenses for housing in remote areas. The allowance is MYR 9,000 on the peninsula, MYR 12,000 and for minor islands. Moreover, MYR 40,000 is furnished as housing repair expense to the hardcore poor.

The Ministry of Agriculture and Agro-based Industry provides MYR 10,000 on the peninsula and MYR 12,000 on minor islands for housing maintenance expenses for persons engaged in the fishing industry. Moreover, housing construction expenses of MYR 40,000 on the peninsula and MYR 50,000 on remote islands is provided.

Syarikat Perumahan Negara Berhad (SPNB), a wholly owned subsidiary of the Ministry of Finance, also sells housing to residents of regional areas at low prices. The SPNB's program called Rumah Mampu Milik (RMM) provides housing to low-income earners, and the prices and square footage of the low-cost, low medium, and medium-cost housing provided in the program are as follow. Because applicants must be between the ages 21 and 50, this is not a program for the elderly, but it is included for reference purposes.

[278] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[279] The following is based on an on-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).

Table 5-2 Classification of Low-cost and Low medium housing

Type	Area	Price (on Peninsula)	Price
Low-cost	700 sq. ft.	MYR35,000～	MYR50,000～
Low medium	750 sq. ft.	MYR50,000～	MYR50,000～
Medium-cost	800 sq. ft. and above	MYR80,000～	MYR100,000～

Source: SPNBwebsite http://www.spnb.com.my/eng/corporate/faq.htm#02 (accessed 13 September, 2013)

Applicants for this program must fulfill the following conditions. [280]

・Malaysian citizen
・From 21 to 50 years old
・Does not own one's own residence or land where a residence could be built
・Household income does not exceed MYR2,000

Local Authorities' Regulations on Private Companies to Secure Housing for Low-income Earners

The local authorities' role in housing services is limited. However, local authorities have the authority to issue permits when private companies construct housing. Local authorities impose a condition that a fixed percentage of housing constructed on land of 5 hectares or more must be housing for low-income earners. To secure a supply off low-income housing, private developers must allocate 30% of housing to low-income housing. [281]

Retirement Village (housing business targeting the elderly)

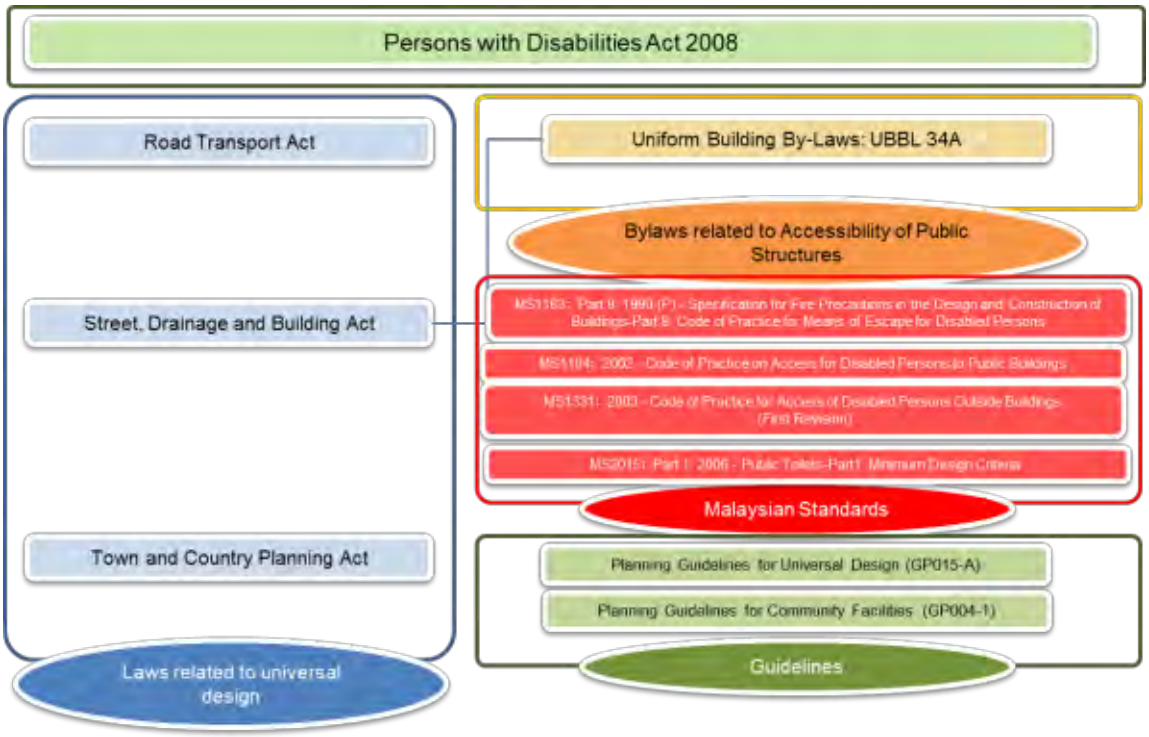
In recent years, a type of housing business targeting the elderly called retirement villages has become popular in Malaysia. [282] These are businesses conducted for profit by private companies that target wealthy elderly persons who are physically independent. The price of housing for the elderly in retirement villages ranges from around MYR 300,000 to MYR 400,000 for one condominium. The price of one condominium at a retirement village in Sepang in the state of Selangor is MYR 960,000. The Ministry of Housing and Local Government is currently studying regulation of the retirement village business.

Guidelines for Universal Design of Public Facilities

In (8) and (9), we cover universal design policy for public facilities, transportation, and

[280] SPNB website http://www.spnb.com.my/eng/corporate/faq.htm#02 (accessed 13 September, 2013)
[281] Bakhtyar, B., A. Zaharim, K. Sopian, and S. Moghimi (2013). "Housing for Poor People: A Review on Low Cost Housing Process in Malaysia," *WSEAS Transactions on Environment and Development*, Issue 2, Volume 9, p.129.
[282] On-site hearing survey on April 22, 2013 (Institute of Gerontology, UPM).

tourist facilities. Universal design policy targets not only the elderly, but rather measures for the elderly are included in PWD policy.[283] Previously, problems of persons with disabilities occupied a low-priority position within social welfare policy.[284] In 2008, the Persons with Disabilities Act 2008 (Act 685) was passed as the first comprehensive PWD act in Malaysia. Article 2 of the act states "'universal design' means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design and shall include assistive devices for particular groups of persons with disabilities where this is needed." Moreover, Article 26 of the act stipulates that the government or the provider of a public facility or service adapts that facility or service so it has universal design so that PWDs can utilize public facilities and services. Article 27 of the act prescribed similar regulations for public transportation.



Source: Japan International Cooperation Agency (2009), *Report on Information Collection and Identification Study for Plan to Create a Barrier-free Society in Malaysia*, pp. 4-6, and Summary of Universal Design Planning Guidelines (GP015-A), prepared by MURC from http://www.townplan.gov.my/download/015A_gpp_universal_design__english_.pdf (accessed 7 January, 2013).

Figure 5-3 Outline of Universal Design Policy

The Federal Department of Town and Country Planning Peninsular Malaysia (FDTCP) under the Ministry of Housing and Local Government is responsible for advising on all

[283] On-site hearing survey on March 21, 2013 (Ministry of Transport).
[284] Rajendran, Muthu (translated by Hisashi Tanaka, translation supervised by Yasuo Hagiwara), *Malaysian Society and Social Welfare*, Akashi Shoten Publishers, p. 213.

planning matters related to land and to assist the federal government, state governments, local authorities and others government agencies in preparing Development Plans, such as the State Structure Plan, District Local Plan and Special Area Plan.

One of the main roles of FDTCP is come up with "Garish Pandean Perancangan" or Federal Planning Guidelines. State Town and Country Planning Department will refer to planning guidelines published by FDTCP to draft the State Planning Guideline and Standards Manual. The State Planning Guideline and Standards Manual serves as a best planning practise for Local Authorities and District Town and Country Planning Department. Each State Government and Local Authority has their own specific standards manual and guidelines for town planning and building, infrastructure, house, etc. [285] For example, Selangor Town and Country Planning Department has published a second edition of Selangor State Planning Standards and Guideline Manual in October 2010. [286]

FDTCP has published 2 planning guidelines to promote barrier free society, namely Planning Guidelines for Community Facilities (GP004-A) and Planning Guidelines for Universal Design (GP015-A). Hence, these 2 guidelines have outlined several barrier free practices for elderly and people with disabilities. [287]

FDTCP is planning to publish a Planning Guideline for Senior Citizens. Currently, the Research & Development Division, FDTCP is conducting a conduct research to seek views from the public, State Government, Local Authorities, non-governmental bodies (NGOs) and relevant technical agencies on this guideline. [288]

Road Transport Department Malaysia (JPJ) has prepared Guidelines for Universal Access Buses for urban and city centre. This guideline is drafted by Automotive Engineering, JPJ in collaboration with NGO and operators (RapidKL). [289] However, this guideline is not yet being implemented. This Buses Guideline is now with Land Transport Commission (SPAD) for review. Once it has been approved by SPAD, it will be implemented in the purchase of new intra-city buses in future. However it is subject to discussion and agreement by the bus operators. [290]

---

[285] Mdm. Noorsiah bt. Arshad, (2013). Technical Assistant. Selangor Town and Country Planning Department. Telephone Interview.

[286] Selangor Town and Country Planning Department, (2012). "Selangor State Planning Standards and Guideline Manual, Second Edition". http://www.jpbdselangor.gov.my/my/perkhidmatan/manual-garis-panduan/manual-garis-panduandan-piawaian-perancangan-negeri-selangor-versi-ke-2.html

[287] FDTCP, (2012)."Function of the Department". Retrieved from http://www.townplan.gov.my/en_content.php?ID=20

[288] FDTCP, (2013). "Public Online Engagement for research on Planning Guideline for Senior Citizen". Retrieved from http://www.mytownnet.blogspot.com/

[289] Mr. Azzaharin, (2013). Assistant Director, Automotive Engineering, JPJ. Telephone Interview.

[290] Mr. Subestheran, (2013). Principal Assistant Secretary, Planning & Research Division, Ministry of Transport

1) Barrier Free Policies and Guidelines

Provisions related to PWDs are prescribed in Section 34A of Malaysia's Uniform Building Bylaws (UBBL). UBBL are bylaws related to accessibility which were enacted based on the Street, Drainage, and Building Act (Act 133). [291] Section 34A(1) provides that PWDs must be able to access all buildings and that facilities must be created that PWDs can use. Section 34A(2) provides that the UBBL must conform to the Malaysian Standards (MS). Specifically, the following Malaysian Standards apply. [292]

1. MS 1184:2002 - Code of Practice on Access for Disabled Persons to Public Buildings
2. MS 1183: Part 8: 1990 (P) - Specification for Fire Precautions in the Design and Construction of Buildings-Part 8: Code of Practice for Means of Escape for Disabled Persons
3. MS 1331:2003 - Code of Practice for Access of Disabled Persons Outside Buildings (First Revision)
4. MS2015: Part 1: 2006 - Public Toilets-Part 1: Minimum Design Criteria.

The buildings subject to UBBL Section 34 are as follow, and single family private dwelling houses are not subject to Section 34 (Section 34A(1)(g)).

1. Offices, banks, post offices, shops, department stores, and supermarkets (excluding shop-houses that serve as both shops and residences which existed prior to the enactment of UBBL34A) (Section 34A(1)(a)).
2. Railroads, roads, ships at sea, air travel buildings and the attached concourse, parking lots, buildings, and factories (Section 34A(1)(b)).
3. Hospitals, healthcare centres, clinics, and other health and welfare facilities (Section 34A(1)(c)).
4. Restaurants, concert halls, theatres, movie theatres, conference halls, community facilities, swimming pools, sports facilities, and other refreshment and recreational facilities (Section 34A(1)(d)).
5. Religious facilities (Section 34A(1)(e)).
6. Schools, vocational schools, colleges, zoos, museums, libraries, exhibition facilities, and other educational, cultural, and scientific facilities (Section 34A(1)(f)).
7. Hostels, hotels, and other residential facilities (excluding single family private dwelling houses) (Section 34A(1)(g)).

[291] Source: Japan International Cooperation Agency (2009), *Report on Information Collection and Identification Study for Plan to Create a Barrier-free Society in Malaysia*, p. 6.
[292] The Ministry of Transport's universal design is also in accordance with the MS1183、1184、and 1131 standards, according to on-site hearing survey on March 21, 2013 (Ministry of Transport).

The Federal Town Planning Guidelines has issued two planning guidelines namely; Planning Guidelines for Community Facilities (GP004-A) and Planning Guidelines for Universal Design (GP015-A).

Planning Guidelines for Universal Design (GP015-A) provides guidelines for PWDs and the elderly and sets forth the standards.[293] The guidelines are a revision of Facilities of the Disabled Planning Guidelines which was prepared in 2000 by the Ministry of Housing and Local Government. GP015-A was drawn up with consideration for all laws and regulations pertaining to PWDs, and as shown in ②, the Malaysian Standards were referenced when drawing up these guidelines.

The Universal Designs are imported into the Planning Guidelines for Community Facilities (GP004-A) in order to ensure all of the communities facilities/buildings such as the hospitals, community centres, libraries, social amenities and others alike are user-friendly for the elderly and PWDs.

2) Planning Guidelines for Universal Design: GP015-A

The scope covered in the Federal Planning Guidelines for Universal Design are as below[294];

a) Footpath

a) Outside buildings

- The footpath should be provided without any physical barrier for clear access to the buildings, recreational areas, public transport terminals, car parks and others.
- Must be illuminated, strong, flat, absorbent and not slippery. (Clause 4.1 and 25.1, MS 1331:2003)
- The path size should be appropriate for all individuals including the wheelchair users with minimum width of 1,500 mm and maximum 3,000 mm. (Clause 4.2, MS 1331:2003)
- If kerb is not available at the footpath, the difference height between the pathway and the road should be maximum of 10mm. (Clause 4.6 MS 1331:2003)
- Guiding block or tactile block must be provided at the main entrances of the pathway as a guide

[293] Summary of Universal Design Planning Guidelines (GP015-A) http://www.townplan.gov.my/download/015A_gpp_universal_design__english_.pdf (accessed 7 January, 2013）

[294] Department of Town and Country Planning Peninsular Malaysia (FDTCP), Ministry of Housing and Local Government, (2011). “Planning Guideline for Universal Design GP015-A” pp.1-25

- If there are bollards, the distance should be at minimum of 900 mm and maximum 1200 mm to give way for the wheelchair users.
- Alarm sign either in the form of sound or light should be provided in the pathway nearby dangerous areas or construction areas (Clause 28.1, MS 1331:2003)
- Covers of ditch/drain should be non-slip and align with the foot path surface. Opening hole between ditch/drain cover should not be more than 13mm wide. (Clause 4.5, MS 1331:2003)
- Any objects such as the trees, vases, street light, chairs and signboards should be placed at the side of the pathway and obstacle-free (Clause 18.1 and 22.2 MS1331:2003)
- Footpath should not be shared with motorcycle or bicycle users to avoid any risk of accidents.

b) Inside buildings

- Pathway should be accessible and obstacle-free from the entrance up until all the levels of the building. (Clause 3.3. MS1184:2002)
- Every pathway and ramp forming part of access for wheelchair user must have a clear width at every part of not less than 1,200mm and gradient maximum is 1:12. (Clause 5.1, MS 1884:2002)
- The route surface should be made from non-slip materials, have different colour and texture to inform potential physical obstacle (Clause 26, MS1184:2002)
- Guiding block or tactile block must be provided at the main footpath as the guidance.

b) Pedestrian crossings

- Step ramp or dropped kerb should be provided at the pedestrian crossing (Clause 6.1, MS 1331:2003). Step ramp also must possess different colour and texture with the side footpath and non-smooth surface (Clause 6.4 MS 1331:2003)
- Guiding blocks/tactile block should be provided at the both ways of the pedestrian crossing(Clause 17.3, MS 1331:2003)
- For the benefits of the blind, traffic lights should have visual and audio signals to guide the pedestrian(Clause 17.5, MS 1331:2003)
- At places where the road is wide and traffic heavy (where the road divider are wide or more than 2,700 mm), the time taken for pedestrians to cross both halves of the carriageway could be so long as to cause traffic jammed and it is better that they be made to cross each half separately by providing a staggered pelican crossings. (Clause 17.7, MS 1331:2003)

c) Guiding blocks or tactile blocks

- Guiding blocks should be provided to assist visually-impaired people where they need either warning of danger ahead such as obstacles and hazards, or guidance as to the correct route to follow. (Clause 12, MS 1331:2003 and clause 15, MS1184:2002)
- Places that should be provided with guiding blocks are:
  - In front of main entrance, lift, escalator, stairs and ramp
  - Main entrance for the pedestrian inside and outside of the buildings
  - Pedestrian crossing
  - Public transport platforms
- Two types of guiding blocks/tactile blocks; line type guiding blocks/tactile blocks and dot type guiding blocs/tactile blocks are the essential route guidance (Clause 12.5, MS1331:2003 and Clause 15.4, MS 1184:2002)
- Line type guiding blocks/tactile blocks is a sign for route to follow. (Clause 12.5 (a), MS1331:2003 and Clause 15.4(a), MS1184:2002)
- Dot type guiding blocks/tactile blocks give warning for the dangerous route upfront, such as approaching road junction and crossroad. (Clause 12.5(b), MS1331:2003 and Clause 15.4(b), MS1184:2002).

d) Parking areas

- Parking area for PWDs or wheel chair users must be provided inside and outside of all public buildings, commercials, public transport terminal, multi-level residential areas as well as recreational areas. For wheelchair users, the parking area outside of building must be constructed with a roof.
- Parking for disabled person should be located at the main entrance. (Clause 21.1, MS1331:2003)
- The parking areas should be at same ground level (Clause 4.2, MS 1184:2002)
- For outside the buildings where there is a footpath at any parking spaces for the disabled persons, a step ramp not less than 1,200mm wide should be provided for users access to it. (Clause 21.5, MS1331:2003)
- Inside the buildings, parking areas should be on the same level, in line with the footpath beside. Otherwise a step ramp or dropped kerb with the minimum width of 1,000 mm and maximum 1,050 mm should be provided. (Clause 4.3, MS1184:2002)
- Parking sign boards for disabled persons should be provided and should be clearly visible upon entering the parking area. The signboard also should be equipped with clear direction symbols. (Clause 4.5, MS1184:2002).
- Parking space for the disable persons should be identified by the symbol painted on the ground surface. (Clause 21.6 MS1331:2003)

·

Source: Planning Guidelines for Universal Design: GP015-A, p.12.

Figure 5-4 Mark Indicating a PWD Parking Space

- The parking areas for disabled persons should be provided with minimum 1 space for 25 public parking spaces
- Minimum size for a parking space at right angle is 3,600 mm width x 4,800 mm length. If the parking space is parallel with the road, the minimum size is 3,600 mm width x 6,600 mm length in order to enable the wheelchair users to get out of the driver's seat and move towards pedestrian pathway. (Clause 21.3, MS1331:2003)

e) Bus Stop

- Facilities like step ramp, dropped kerb, ramp, guiding blocks, and railings should be provided at the bus stops.
- The floor level shall be the same with the bus floor level to facilitate all individuals' embarking and disembarking the vehicle.
- The floor of the bus stops should be non-slippery.
- Adequate lightening must be provided at the bus stop.
- Benches/seats must be safe, comfortable and built from the suitable materials.
- Bus stop should be designed to assist the bus stopping next to kerb making it easy for passengers to get on board.
- The embossed bus route number must be provided at the bus stop's glass wall for the visually-impaired people directory (Clause 5, 18, 19 and 24 MS 1331:2003).

f) Main entrance

- Every building must have doorway at the entrance floor providing access for wheelchair users into the buildings. (Clause 6.1, MS1184:2002)
- If the main entrance of the buildings is not accessible by wheelchair users, then a sign directing the wheelchair users should be provided at the main entrance to guide them towards the alternative doors. (Clause 6.3 and 28, MS1184:2002)
- Guiding blocks/tactile blocks must be provided at the entrance and exit way of the buildings. The floor surface must use materials and colour contrast (Clause 25.2, MS 1331:2003) as a warning sign for the visually impaired people.
- The main entrance should have the minimum width of 900 mm. While for hospitals and sport complexes the minimum width is 1,000 mm. (Clause 8.1, MS 1184:2002). The turning radius for the wheelchair users must be provided with the minimum diameter of 1,200 mm (Clause 8.3, clause 14, MS1184:2020)
- Ideally an automated glass doors must be provided. Otherwise the entrance should use doors that can be opened by one hand with a lever handle of maximum height 1,200 mm from the floor (Clause 27.1, MS1184:2002)

g) Step ramp or dropped kerb.

a) Outside buildings

- Step ramp or dropped kerb must be provided at the pedestrian cross, traffic junction, bus stops, etc. (Clause 6.4 MS1331:2003)
- Step ramp or dropped kerb must have different colour or texture with the footpath beside and the surface should be non-slippery (Clause 6.4, MS1331:2003)

b) Inside buildings

- If the floor level at the entrance of the building does not exceed from 215 mm either above or below the footpath, step ramp or dropped kerb must be provided. (Clause 7.1, MS1184:2002)
- Step ramps or dropped kerb should have a non-slippery surface (Clause 7.4, MS1184:2002)

h) Ramp

- Ramp must be provided inside and outside of all public and commercial buildings, public transport terminals, parking areas, multi-level residence and recreational areas to connect it with the footpath.

- The maximum gradient of the ramp is 1:12, (Clause 7.2(a), MS1331:2003, Clause 5.1(b), MS1331:2003 and Clause 5.1(b), MS1184:2002) and the minimum width is 1,200 mm (Clause 7.2(d), MS1331:2003, and Clause 5.1(a), MS1184:2002)
- A ramp without barriers on both left and right sides must be provided with kerb, at a minimum height of 100 mm for the safety of wheelchair and walking stick users. (Clause 7.5, MS1331:2003, and clause 5.2(c), MS1884:2002)
- Guiding blocks/ tactile blocks must be provided at the beginning and ending of the gradient ramp to provide warnings for the visually impaired people.
- The ramp surface must not be slippery and made of suitable materials (Clause 25, MS1331:2003 and clause 26, MS1184:2002)
- Minimum of 1 ramp should be provided at each row of shop houses or offices.

i) Handrail

- Handrails must be provided at the footpath, buildings corridors, ramp and staircase for safety purposes of all individuals. (Clause 11, MS1331:2003 and Clause 12, MS1184:2002)
- Handrails must be built at a minimum 840 mm and maximum 900 mm from the floor level (Clause 11.2(a), MS1331:2003 and Clause 12.1, MS1184:2002)
- Handrails must have space minimum 50 mm and maximum 100 mm from the building's wall. (Clause 11.2(d), MS1331:2003 and Clause 12.5, MS1184:2002)
- Handrail must have diameter/width minimum 40 mm and maximum 60 mm and must non-slippery and safe for grabbing. (Clause 11.3, MS1331:2003 and clause 12.2, MS1184:2002)

j) Signboard and symbol

- International symbol of access for wheelchair users is painted with white colour with blue colour background. (Clause 20.4, MS1331:2003 and Clause 28.1, MS1184:2002)

Source: Planning Guidelines for Universal Design: GP015-A, p.18.

Figure 5-5 Access Symbol for Wheelchair Users and PWDs

The location of the PWDs or wheelchair user's sign should be at the parking areas, footpath, main entrance, alternative entrance, reception areas, lobby, lifts, and toilets and emergency doors. (Clause 28.3, MS1184:2002)

- The font size, type and writing of the sign must be clear and easy to read. (Clause 28.6 MS1184:2002)
- Signboards with Braille writing must be provided for the visually impaired. (Clause 28.7, MS1184:2002)
- Signage statement or floor plan inside and outside of buildings must be provided to show the facility location for disable persons, such as toilets, lifts, emergency exits, parking areas, bus stops, recreational area, etc. (Clause 20.3, MS1331:2003 and Clause 28.5, MS1184:2002)
- Signage to alert vehicle and road users the usual location of PWDs must be provided for safety purposes. (Clause 20.1 MS1331:2003)

k) Stairs, lifts and escalators

- Stairs, lifts and escalators must be provided for the access to individuals at multi-level buildings (Clause 8.1 & 10.1, MS1331:2003 and Clause 9.1 & 11.1, MS1184:2002)
- Specifications of stairs construction must comply with Clause 9, MS1184:2002
- Guiding blocks or tactile blocks must be provided at stairs, lifts and escalators as a sign of physical obstacles and warning of the potential accident for the visually impaired (Clause 12.1(a), MS1331:2003 and Clause 15.1(a), MS1184:2002)

- Minimum of 1 lift should be provided near to the main entrance that can be accessed by the wheelchair users with space to turn around at 180 degree. (Clause 9.4, MS1331:2003 and Clause 10.4, MS1184:2002)

l) Toilet

- Toilets for wheelchair users must be provided in all public and commercial buildings, recreational areas, and public transport terminals.
- Number and design of the toilets must comply with Clause 16,17,18, 20,22, and 26 MS1184:2002 (Clause 18.13, MS13331:2003) and MS2015:Part 1:2006
- Minimum number of toilets with wheelchair user facilities is one toilet out of 10 normal toilets (Clause 5.5., MS2015: Part1:2006). The minimum size is 2,000 mm x 2,400 mm. The minimum size for toilet other than for wheelchair users should be 1,200 mm x 2,400 mm and be equipped with a grab bar.
- The toilet symbol for men and women must be embossed or use Braille writings to guide people with visual impairment. (Clause 28.7, MS1184:2002)

m) Landscape

a) Public phone

- Minimum 1 public phone especially for disabled persons should be provided at public areas.
- The features of special public phone should include:
  - Unobstructed access to the phone
  - Direction sign board
  - Suitable design at the appropriate height, maximum of 1,000 mm from the floor level
  - Additional support devices if necessary
  - Phone location is not blocking ways
  - Adequate lightening
- All of this facilities must comply with Clause 27.4, MS1184:2002

b) Public seating areas

- Must be provided in public areas that can be used by everyone
- Must be provided at areas that can be easily accessed, such as along walkways
- The design must meet the safety terms, suitable heights and other appropriate features. Minimum height is 420 mm and maximum 450 mm from the floor level
- All of the above descriptions must comply with Clause 19, MS1331:2003

c) Mail box and trash bin

- The location, design, and heights must be suitable for everyone
- The height of the mail box slot hole and the trash bin hole must not exceed 1,000 mm from the floor. (Clause 18.8, MS1331:2003)

d) Safety fence

- Must be provided around man-made lakes and ponds that are commonly visited by public
- The design and construction must have safety and robust features
- The minimum height is 1,200 mm from the floor
- Safety fence must be supported by guiding blocks as a guide to visually impaired people.

n) Automated Teller Machine (ATM)

- The location, design and height should be appropriate for all individuals. Bank note and card slot maximum height is at 1,000 mm from the floor. (Clause 27.4, MS1184:2002)

(6) Creating Universal Access to Transportation

1) Guidelines for Universal Access to Buses (in urban and central city areas) [295]

The Guideline for Universal Access Busses for Urban and City Centre provided by Road Transport Department Malaysia are as follows:

a) Bus stops

- The platform at the bus stops in the city, shall be built to a height between 203 mm (8 inches) to not more than 228 mm (9 inches) from the road surface.

b) Buses

- Buses shall be low-floored. At least 35% of the area available for standing passenger can be reached from the entrance and exit without an internal step.
- Shall have a feature constructed so as to be lowered and raised.
- Shall have the ability to be lowered or 'kneel' to a maximum height of 254 mm (10 inches) from the floor level to the road surface.
- The ramp for boarding the bus should be not less than 760 mm in length and not less than 850 mm in width.

[295] Road Transport Department, (2012). "Guideline for Universal Access Busses for Urban and City Centre". Pp.1-6

- The distance between the bus stop kerb and bus shall not be more than 300 mm
- The gradient of the bus ramp when it is deployed shall not be steeper than 1:10
- Where the ramp stows in the floor of the bus, the edges of the storage space shall not be higher than 22 mm and the slopes of the edges shall not be steeper than 1 in 2
- The area of accommodation shall not be less than 1,600 mm in length and not less than 750 mm in width.
- A suitable padded back rest of width between 250 mm to 270 mm shall be provided and firmly fixed to a position that will prevent injury during emergency stop. This shall extend from a height of 500 mm above the floor to a height of at least 1,300 mm above the floor and shall have a clear space of at least 250 mm deep either side of and below the backrest for the wheels of the wheelchair.
- A handrail shall be fitted to the wall at the position for the passenger in a wheelchair at a height of 850 mm to 900 mm from the floor level, and not less than 1,250 mm in length. There shall be a clear space between 40 and 50 mm between the handrail and the wall of the bus.
- The accommodation for disabled person or wheelchair shall be provided in the city bus in rearward facing position. There shall not be any seat constructed in the access or passage area.
- A stanchion shall be erected to prevent the disabled passenger wheelchair moving sideways with the bus sways to the side. The stanchion shall be erected 450 mm from padded back rest, and 750 mm from the handrail.
- There shall be two wheelchair accommodations for a 12 meter bus and at least one accommodation for bus less than 12 meter length.

c) Other features of the bus

- A safety seatbelt for wheelchair users shall be installed, consisting of a seat belt retractor and seat belt buckle.
- The anchorage points shall be fitted to best possible position for such fitting.
- Seatbelt retractor shall be fixed between 500 mm to 550 mm from the floor, which is about the height of an armrest of a small wheelchair. Stalk with seat belt buckle shall be fixed between 550 mm to 600 mm from the floor
- In addition, at least two seats shall be provided in the bus for other disabled passengers (non-wheelchairs users) and those less mobile (pregnant women, elderly, parents with small children). The seating area shall be indicated with signage.
- There shall be a bell push within the reach of the passenger in a wheelchair that makes a sound different from the sound caused by the other bell pushes.

- The bus shall be equipped with a public address system to provide visual and audio information to all passengers.
- The audio visual screen shall be so placed to the bus as to give adequate information to the disabled passenger boarding the bus.
- Buzzer with beeping sound shall be fitted to indicate door opening or closing.

(7) Universal Design in Tourist Facilities

The policy for universal design in tourist areas is under the jurisdiction of the Development Division in the Ministry of Tourism and Culture. This division is involved in the ministry's tourism projects and granting funds from the ministry, and it directly plans, implements, and monitors tourism projects implemented by state governments. [296] The Development Division is not the organization responsible for projects implemented by state governments; however, state governments submit their requests for tourism infrastructure development projects to the Ministry of Tourism and Culture, and then the Development Division screens the requests and determines whether or not to grant the funds. Infrastructure development projects by the private sector are outside the jurisdiction of the Ministry of Tourism and Culture.

Installation of universal design is a part of tourism infrastructure development, and if a universal design installation project planned by a state government is approved by the Development Division, funds are granted for the project.

The goal of universal design installation projects is to improve accessibility for all people in order to meet their needs, including those with special needs. [297] One of the characteristics of universal design installation in tourist areas is that it is not targeted specifically for the elderly but rather the universal design policy for PWDs and people with special needs also includes measure for the elderly. [298]

An example of a specific universal design installation projects is installation of toilets, changing rooms, and a canopied walkway at the beach. For example, in the case of toilet installation, when four toilets are installed, one of those is a toilet for PWDs. One of the greatest needs for universal design is in the improvement of use-friendliness for wheelchairs by, for example, installation of interlocking tiles. [299]

An issue faced by the Ministry of Tourism and Culture in promoting the installation of

[296] Ministry of Tourism and Culture Malaysia website http://www.motac.gov.my/en/ministrys-profile/division-unit/development-division.html (accessed 9 September, 2013)
[297] On-site hearing survey on March 18, 2013 (Infrastructure Development Division, Ministry of Tourism).
[298] On-site hearing survey on March 18, 2013 (Infrastructure Development Division, Ministry of Tourism).
[299] On-site hearing survey on March 18, 2013 (Infrastructure Development Division, Ministry of Tourism).

universal design is lack of funds.[300] Because the Ministry of Tourism and Culture itself is not allocated adequate funds, it must cut budgets even for necessary projects. Regions with forests and waterfalls where ecotourism is possible are considered important by the ministry, and the ministry needs a budget for ecotourism in regions such as the state of Sabah. Although forests and waterfalls are important tourism resources, they are in regions that are not easily accessible by the elderly. So, there is a need to improve the accessibility of forest regions, but state governments do not have the funds to install such facilities. Since improvement of the accessibility of forest regions would lead to increased participation in tours from elderly people from other countries, which may be expected to increase tourism income, Ministry of Tourism and Culture places priority on the improvement of accessibility to forest regions.

5.4. Main Issues

(1) Deployment of Disjointed Housing Policies by Various Ministries and Departments

As stated above, various ministries, departments, and other agencies in the Malaysian government are implementing housing policies. Because some of the services are redundant, it is argued that implementation of housing policy should be assigned to one body. The Malaysian government has hired a consultant and is currently studying the matter.[301]

(2) Housing Provided by the Ministry of Housing and Local Government Displays the Letters "KPKT," Which Creates a Stigma

The letters "KPKT," the initials of the Ministry of Housing and Local Government, are clearly marked on the outside walls of the public housing provided by the ministry. So, people know that residents living in public housing with the letters "KPKT" are low-income earners. Newer public housing does not cause such a stigma because it has all the modern facilities, but older public housing carries a strong stigma.[302] For this reason, the ministry is considering altering the name given to public housing.

(3) Implementation of Universal Design Policies is Inadequate

Malaysia's universal design policy is taking shape with the enactment of the Persons with Disabilities Act (Act 685) in 2008, and other laws. However, reconstruction and remodeling

[300] On-site hearing survey on March 18, 2013 (Infrastructure Development Division, Ministry of Tourism).
[301] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).
[302] On-site hearing survey on April 19, 2013 (Policy and Strategic Planning Division, Ministry of Urban Wellbeing, Housing and Local Government).

of existing buildings so they meet Malaysian Standards is not progressing. Even when buildings are reconstructed and remodeled, experts have pointed out that some still do not meet Malaysian Standards (for example, toilet doors installed so that they open and close in the wrong direction). [303]

Kamal Malhotra, former United Nations Resident Coordinator, points out that there is a shortage of experts who are familiar with universal design and that it is necessary to clarify which bodies are to implement the policies and guidelines. [304]

[303] Kadir, Syazwani Abdul and Mariam Jamaludin (2012), "Applicability of Malaysian Standards and Universal Design in Public Buildings in Putrajaya," *Asian Journal of Environment-Behaviour Studies*, Vol.3, No.9, p.22.
[304] Malhotra, Kamal (2010), "Introductory Remarks: National Conference on Accessibility and Universal Design: Implications for Public Transport and the Built Environment," p.3.
http://www.undp.org.my/files/media/25/27.pdf (accessed 9 January, 2014)

6. Other Elderly-Related Measures

6.1. Outline

This chapter discusses low-income population database (E-Kasih), tax collection system, civil registration system, voter registration, census, as well as food, fuel, and other grant benefits, with a primary focus on the ability to ascertain the persons eligible for social security benefits.

E-Kasih, introduced in 2007, is a database designed to eliminate dual receipt of benefits from more than one social security program at the same time and grasp, manage and assist low income households. It was developed by the ICU affiliated with the Prime Minister's Office. The database contains information on household heads, household members, and household income, and so on. With regard to the tax collection system, the Inland Revenue Board of Malaysia (IRBM) is responsible for the management of taxes including income tax, petroleum income tax, and real property gains tax. With regard to the civil registration system, the National Registration Department (NRD) is responsible for the registration and management of birth, death, adoption, and so on. An ID card such as MyKad is issued to registered citizens.

In Malaysia, people must conduct a voter registration with the Election Commission to exercise their voting rights. Malaysian citizens aged 21 or older are eligible for voter registration. The census is conducted by the Department of Statistics once in 10 years.

One of the assistance programs for the poor is the food basket initiative. Under this initiative, people who are registered on E-Kasih and receive assistance from the ICU are eligible for a benefit of MYR 80 per month.

Malaysia is making efforts to ascertain persons eligible for social security benefits accurately, by such means as the introduction of E-Kasih. However, there are some data collection issues, such that E-Kasih's evaluation system is not based on statistically adequate standards and that a half of poor households are not included in E-Kasih, as pointed out in a World Bank report.

6.2. E-KASIH [305]

(1) Outline of E-KASIH

In Malaysia, a database called E-KASIH [306] has been established since 2007 for the purpose of grasping and managing accurate information on low-income households and providing appropriate assistance.

[305] Additions and modifications were made to JICA (2012), Malaysia," in JICA, *Data Collection Survey on Social Security Sector in Asia Final Report: Country Report*, pp. IV-30-31.
[306] *Kasih* means "love" in Malayan.

This system was developed by the Implementation Coordination Unit (ICU) affiliated with the Prime Minister's Office. The ICU develops and manages the database that contains information about each household and individual, provided by each ministry. For example, if the Ministry of Education (MOE) provides a scholarship or assistance benefit to a low-income student, the student is registered on the list of E-KASIH. In addition, if any ministry provides financial assistance, the name of the recipient individual or household is registered on the list, and the list of low-income persons is shared by ministries and agencies. When the assistance is provided, the identification card (ID) is checked to verify identity. eKasih keeps detailed profiling of the poor and extreme poor as a base for national poverty program planning and aid distribution. Information collected are:

- Detail of program/project information
- Head of household (HOH) profile
- Member of household (MOH) profile including details of location, residence, education, skills and job, property ownership, health
- Household income
- Aid received

(2) Background

When the Federation of Malaya was founded in 1957,[307] nearly 70% of the population lived in poverty, and a budget for poverty reduction was allocated to each ministry to implement separate programs. However, with the increase in those who receive assistance from more than one ministry at the same time, a concern arose that the assistance may not reach all those who are really in need. In view of such situation, it was realized that, in order to distribute the limited resources properly, a unified system to ascertain the information on eligible persons was necessary and thus it was decided to introduce this system.

(3) Range of database utilization

In E-KASIH, about 1.5 million persons, or about 330,000 households are registered, which accounts for about 4% of the population (as of 2010). The list includes the "poor" and the "very poor," who are eligible for assistance in Malaysia.

Poverty status is automatically calculated by the system based on household income and Poverty Line Income (PLI). With the implementation of eKasih, the PLI used is standardized

[307] In 1957, the Federation of Malaya attained independence as a member of the Commonwealth. In 1963, Malaysia was formed with Sarawak, the British territories in North Borneo (current Sabah), and Singapore, and Singapore separated and became an independent nation in 1965.

and uses as the criteria to determine the poverty status (poor or extreme poor). [308]

Table 6-1 Changes in Poverty Income Line (Unit: MYR)

2004	2007	2009
691	720	760

Source: MRUNInets website.
http://murninet.townplan.gov.my/murninets/nodes/view/type:petunjuk/slug:et2-p2-kadar-kemiskinan (accessed 11 October, 2013)

Table 6-2 Poverty Line Income (PLI) 2009 by Region (MYR per Month)

Region	Poor		Extreme poor	
	Household	Per Capita	Household	Per Capita
Peninsular Malaysia	760	190	460	110
Urban	770	200	450	120
Rural	740	170	490	110
Sabah & Labuan	1,050	230	630	130
Urban	1,020	230	590	130
Rural	1,080	230	670	140
Sarawak	910	210	590	130
Urban	940	210	600	130
Rural	880	210	580	130

Source: Economy Planning Unit (EPU)

In 2007, Malaysia set the targets of reducing the percentage of the very poor from about 0.7% to 0%, and that of the poor from 3.6% to 2.8%. As a measure to achieve these targets, site visits and interview surveys are conducted targeting the households below the poverty line (monthly household income MYR 1,500 in urban areas and MYR 1,000 in rural areas) to determine who is eligible for assistance.

In Malaysia, the low-income population is defined as those who fall into the low 40% range from the poorest. Today, approximated 10 million persons fall into this group. The monthly household income of this group used to be assumed at around MYR 1,500. As for the income levels now, with the rise of income levels, the definition was changed to those with a household income of MYR 2,300/month.

Through the establishment of eKasih, an online open registration was introduced which provides a gateway for the public to register online. The citizen can register for themselves or on behalf of the poor. Each registered case will be investigated by statisticians at the State Development Office (SDO) of ICU JPM at the respective states. An on-site detailed verification is arranged and tabled to the Focus Group committee at the district or state level

[308] Murninets, (2013). “Poverty Line Income”. Retrieved from http://murninet.townplan.gov.my/murninets/nodes/view/type:petunjuk/slug:et2-p2-kadar-kemiskinan

for endorsement before necessary aid is given.

(4) Achievement

The statistics indicate that the implementation of eKasih has significant impact on the reduction of the poverty rate. Since it was rolled out in July 2008, monthly tracking reports from eKasih show a significant reduction of the poor and extreme poor in the system, as a result of aid and suitable programme/project given to the right target. As of November 2011, about 70,000 poor and extremely poor had come out of poverty and the number will increase markedly by end of this year.

Currently, there are more than 400,000 heads of household and more than 1 million members of household registered and verified in eKasih. As of December 2012, 161,840 heads of household from poor and extreme poor households are elderly, and 710,515 members of poor and extreme poor households are senior citizens. However, the World Bank indicates that E-Kasih does not have comprehensive database on the poor, and the poor registered in E-Kasih are only about one half of households estimated to be poor. [309]

Table 6-3 E-Kasih Database by Categories, 2009-2012

Year	Extreme Poor	Poor	Vulnerable	Exceed Threshold	Total
2009	43,423	70,847	109,699	4,571	228,540
2010	8,218	90,396	134,225	41,089	273,928
2011	18,294	109,766	160,990	76,836	365,886
2012	54,295	107,862	116,748	145,795	424,700

*Vulnerable - Those who have incomes above the poverty line and their household incomes are about MYR1500.00 for the city or MYR1, 000.00 for rural areas.
Source: Implementation Coordination Unit, Prime Minister's Department

[309] World Bank (2012), *Malaysia Elderly Protection Study,* p.65.

Table 6-4 No. of Head of Household More Than 60 Years Old from Poor Households in eKasih Database, December 2012

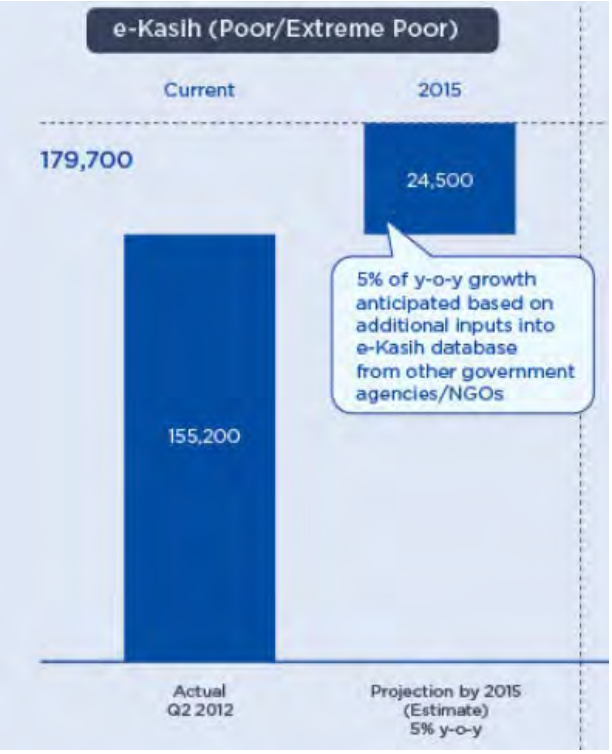
State	Poor	Extreme Poor	Total
Sabah	21,008	26,087	47,095
Sarawak	25,478	19,539	45,017
Kelantan	21,869	2,823	24,692
Perak	6,995	1,020	8,015
Terengganu	6,806	146	6,952
Selangor	4,848	1,147	5,995
Kedah	4,359	718	5,077
Pulau Pinang	3,189	316	3,505
Johor	2,728	379	3,107
Pahang	2,635	371	3,006
Negeri Sembilan	1,857	495	2,352
Perlis	1,851	339	2,190
Melaka	1,883	190	2,073
WP Kuala Lumpur	1,575	470	2,045
WP Labuan	636	72	708
WP Putrajaya	10	1	11
Total	107,727	54,113	161,840

Source: Implementation Coordination Unit, Prime Minister's Department

Table 6-5 No. of Household Member More Than 60 Years Old from Poor Households in eKasih Database, December 2012

State	Poor	Extreme Poor	Total
Sabah	79,559	133,041	212,600
Sarawak	92,306	81,904	174,210
Kelantan	100,027	15,000	115,027
Perak	29,681	4,402	34,083
Terengganu	35,227	524	35,751
Selangor	22,683	5,669	28,352
Kedah	19,907	3,828	23,735
Pulau Pinang	14,291	1,485	15,776
Johor	13,018	1,843	14,861
Pahang	13,284	1,964	15,248
Negeri Sembilan	8,319	2,243	10,562
Perlis	7,618	1,285	8,903
Melaka	8,447	879	9,326
WP Kuala Lumpur	6,921	1,920	8,841
WP Labuan	2,826	339	3,165
WP Putrajaya	63	12	75
Total	454,177	256,338	710,515

Source: Implementation Coordination Unit, Prime Minister's Department



Source: Government Transformation Program Annual Report 2011 [310]

Figure 6-1 Projection of eKasih by 2015

(5) Issues for the Future

The method with which to identify those who should receive public assistance and the appropriate update of their information and data (while ensuring sustainability) are some of the issues to be addressed. How to raise awareness among the recipients who are not willing to work is another issue. In this regard, the government is endeavoring to improve their attitude by providing education and training mainly to the younger generations, who are relatively adaptable.

Additionally, the World Bank points out that the E-Kasih database is not utilized by all the government agencies and that only a part of the programme is implemented when the database is used. [311] Moreover, according to the World Bank, the E-Kasih's evaluation system is not based on statistically adequate standards and lacks a verification system for confirming questionnaire data. For example, it lacks income-related definitions, income source lists, and standards to discriminate agricultural income from self-consumption.

[310] PEMANDU (2011). "GTP Annual Report 2011, Raising Living Standards of Low Income Households".
[311] World Bank (2012), *Malaysia Elderly Protection Study,* pp.65-66.

6.3. Process and Implementation Systems for Tax Collection

(1) Inland Revenue Board of Malaysia

IRBM is a government agent who is responsible in the administration, assessment, collection and enforcement of income tax, petroleum income tax, real property gains tax, estate duty, stamp duty and other taxes agreed between the government and the Board.

As for the personal income tax, only those who are eligible to pay tax are required to register with IRBM. For employees who meet a certain income level and entitle for the taxation, they have two option of registration; either register by themselves or employers will register for them. For those who do not work for a company, they are responsible to personally register with IRBM either at the counter or online. Legal action will be taken for those who are eligible but not registered. This is because IRBM has their own investigation teams, methods, and audit tools used to detect the unregistered tax payers. [312]

(2) Responsibilities of the Employers towards Tax Payments

According to Section 83 (1A) of the Income Tax Act 1967, with effect from year of assessment 2009, every employer has to prepare and deliver for any year specified the employees' remuneration statements on or before the last day of February every year. [313] The required information requested is as below:

- The names and places of residence of such classes of persons employed by the employer as may be indicated in the order.
- The full amount of the gross income falling within section 13 paid payable or provided by or on behalf of the employer to those persons in respect of their employment.

Specifically, the employer must notify the nearest assessment branch within one month from the date of employment commencement of an individual who is subject to or may be subject to income tax. In addition, employers will be responsible for paying any tax due of the employees mentioned [Section 107 (4), Income Tax Act 1967].

Moreover, the employer is responsible for notifying IRBM at least thirty days before the date the employee ceases employment if:

- Employee is about to retire.
- Employee is subject to Monthly Tax Deduction (MTD) scheme and the employer has not made any deduction.
- Employee is about to leave Malaysia permanently.

---

[312] Rohana Bt. Ibrahim, Assistant Director, Communication Department, IRBM. Telephone Interview

[313] KPMG, (2000). "INCOME TAX ACT 1967 (ACT 53)". Retrieved from. http://www.kpmg.com.my/kpmg/publications/tax/22/a0053s0083.htm

The employer must withhold money payable to the employee until they receive a Clearance Letter from the Assessment Branch. However, the employer is not required to send notification about the employee ceasing employment or withhold money payable to him if:

- Employee is subject to MTD and deduction has been made by the employer.
- Employee's remuneration is less than the minimum income subject to MTD.
- Employer is aware that the employee is to be employed elsewhere in Malaysia.

(3) Employee's Personal Income Tax

An employee whose monthly remuneration after EPF deduction is above MYR 2,451 is liable for Monthly Tax Deduction (MTD). Meanwhile, those whose income after EPF deduction is less than MYR 2,451 are still liable for taxes but not eligible for MTD. Employees are responsible for registering income tax filings if their employer fails to do so. [314]

The Monthly Tax Deduction amount is determined according to the employee's residence status. Non-resident employees refer to those who are:

- Employed outside Malaysia.
- Attending any course of study in any institution or professional body outside Malaysia which is fully-sponsored by the employer.

The MTD of an employee who is not resident or not known to be resident in Malaysia shall be calculated at the rate of 26% of his remuneration. In contrast, the MTD of an employee who is resident or known to be resident in Malaysia is derived after deducting all allowable deductions under the Act. [315]

6.4. Civil Registration System, Voter Registration, and Census

(1) Civil Registration System

1) National Registration Department

The National Registration Department (NRD) is a department under the purview of the Ministry of Home Affairs. [316] It is responsible for the registration of important events of every individual such as birth, death, adoption, marriage and divorce. In addition, NRD is also responsible for determining citizenship status and subsequently, the issue of

[314] Inland Revenue Board Of Malaysia, (2013). "Schedule Of Monthly Tax Deductions". Retrieved from http://www.hasil.gov.my/pdf/pdfam/JADUAL_PCB_2010.pdf

[315] IRBM, "Issues Relating To Employees". http://www.hasil.gov.my/goindex.php?kump=5&skum=3&posi=1&unit=5100&sequ=9 (accessed 11 October, 2013)

[316] National Registration Department, (2013)."Registering the Normal Death". Retrieved from http://www.jpn.gov.my/perkhidmatan/kematian/semenanjung/daftarbiasa

identification document in the form of identity card to eligible individuals, like MyKid, MyKad, and so on.

2) Birth Certificate

The birth of every child born in Malaysia must be registered within 14 days from the birth date. The application to register the birth of a child can be made at any NRD office by submitting the fully completed Form JPN.LM01 together with supporting documents. The supporting documents required are parents' identification documents or a valid travel document, prenatal examination documents, confirmation of birth or stillbirth and marriage document of the parents. Birth certificate is compulsory for all babies born in Malaysia regardless the nationality of their parents. [317]

3) MyKid

In 2005, the government introduced MyKid, a registration systems for newborn babies instead of birth certificate. MyKid is the identity card or identification document with a chip issued to a child under the age of 12. Its features are similar to those of MyKad except that it does not contain a photograph or thumbprints. However, the function and usage is still limited to the hospital and school purposes. Other registrations like passport registration still require a birth certificate. MyKid currently stores only 3 types of data; birth data, health information and education information. Nevertheless, MyKid is non-compulsory as compared to birth certificate. For registration of new birth, MyKid will be processed during the application for registration of birth. [318]

4) MyKad

All Malaysian citizens must register MyKad or Identity Card when their ages reach 12 years old at any NRD office. The Government Multi-Purpose Smart Card Project (MPSC) or MyKad is part of the Multimedia Super Corridor (MSC Malaysia) initiative. [319] It is one of seven flagship applications identified for development by the Government of Malaysia to produce world-class innovative technologies in the country. The information that can be accessed includes name, address, identity card number, photograph, fingerprint minutiae, race, citizenship status, religion and etc.

[317] National Registration Department, (2013).“Service Birth Certificate”. Retrieved from http://www.jpn.gov.my/en/servicebirth-peninsular
[318] National Registration Department, (2013).“MyKid”. Retrieved from http://www.jpn.gov.my/en/informasi/mykid
[319] National Registration Department, (2013). “Introduction to MyKad”. Retrieved from http://www.jpn.gov.my/node/4727

5) MyPR

MyPR is an identity card or personal identification issued to residents of Malaysia with permanent resident status. All residents of Malaysia with permanent resident status are required to change their identity card to MyPR with effect from 1 June 2006. The MyPR is red in colour, and visible data included are NIRC number, name, permanent address, gender and permanent residence status. First application of MyPR can be made at the NRD headquarters, in Putrajaya and NRD state offices only. Replacement applications can be made at any NRD counter. [320]

6) MyKAS

MyKAS is the temporary resident identity card which is issued under Regulation 5 (3) of the National Registration Regulations 1990. It has an expiry date of less than five years from the date of issuance of the card. MyKAS must be renewed within 5 years. MyKAS is given to a person who enters to Malaysia legally and possess a valid immigration pass or permit for a period of 12 months and above. [321]

7) myIDENTITY

In 2012, the government has introduced a new database system, namely "myIDENTITY" under the management of National Registration Department. This database keeps all basic personal information of each person registered under the National Registration System. [322] The basic personal information refers to postal address, date of birth, gender, mobile phone number, and email address. Indeed, "myIDENTITY" database is linked and can be assessed by the government participating agencies which are National Registration Department, Immigration Department of Malaysia, Inland Revenue Board of Malaysia, and Road Transport Department of Malaysia. This basic information also can be checked and updated by each person according to the requirements set.

The purpose of this system is to simplify all transactions conducted in these four government agencies where all of the records can be traced using the NRIC number. For instance, when an employee performs any transaction with IRBM, he does not need to remember his EPF number anymore, because now his NRIC number can be used to trace the EPF account. This is also applicable to the other three participating government agency mentioned. [323]

---

[320] National Registration Department, (2013)."MyPr". Retrieved from http://www.jpn.gov.my/en/informasi/mypr

[321] National Registration Department, (2013)."MyKas".Retrieved from http://www.jpn.gov.my/en/informasi/mykas

[322] Ministry of Women, Family and Community Development.(2013) "MyIdentity". Retrieved from https://www.myidentity.gov.my/mengenai-myidentityEng/

[323] Ruzita, Executive Officer of Technology Unit, National Registration Department. Telephone Interview, 14 March 2013

8) Registration Process of the Natural Death

Applicants of common obituary death in Malaysia must be registered within a period of 7 days from the date of death. Applicants must fill in a form called JPN.LM02 and must be submitted together with the supporting documents at any National Registration Department Office throughout Peninsular Malaysia. The supporting documents are

1. Original Identity card or any identification document of the deceased.
2. Identity card or any identification document of informer.
3. Documentary proof of death, such as burial permit, which has been issued reporting to the Police Station for death occurring at home, or reported to hospital for death occurring at a hospital.
4. Certificate by a medical practitioner concerning the cause of death [Form JPN.LM09 or JPN.LM10 (Post Mortem)]

(2) Voter Registration System

In Malaysia, people must make a prior voter registration with the Election Commission in order to exercise their voting rights. Persons who meet the following requirements are eligible for voter registration. [324]

- Malaysian citizen
- 21 years old or older
- Living in the election district where the person hopes to make a voter registration
- Not deprived of the voter registration rights by law

Voter registration can be made at an outreach booth set at the Election Commission headquarters, state offices, post offices, shopping centers, or through an assistant registrar appointed by the political parties, government agencies, or NGOs. [325] There are a total of over 1,000 voter registration facilities in Malaysia, including 700 post offices, which account for over 50% voter registrations. [326] MyKad is required for voter registration. [327]

The voter registration system was revised in 2002. Before 2002, people could register only in a certain period after reaching the age of 21. After 2002, the limitation on the period was removed and the registration became available every day. [328] Additionally, post offices were

[324] Election Commission website http://www.spr.gov.my/spr2013/index.php?option=com_content&view=article&id=209-eligibility-requirements-&Itemid=196 (accessed 11 October, 2013)
[325] Election Commission website http://www.spr.gov.my/spr2013/index.php?option=com_content&view=article&id=210-registration-centres&Itemid=198 (accessed 11 October, 2013)
[326] On-site hearing survey on March 18, 2013 (Election Commission）
[327] Election Commission website http://www.spr.gov.my/spr2013/index.php?option=com_content&view=article&id=214-registration-process&Itemid=197 (accessed 11 October, 2013)
[328] On-site hearing survey on March 18, 2013 (Election Commission）

added as a place for registration in 2002. These revisions made voter registration easier but the voter registration rate declined because people no longer need to rush as they did in the past, when many people rushed for registration immediately before the end of the limited period.[329] As of 2012, there are 3.2 million unregistered persons who are aged 21 or older. The Election Commission encourages unregistered people to do their a voter registration but does not know details of these people.[330]

In respect of data linkage with other ministries and agencies, data are cross-checked with NRD data to confirm names, addresses, and other personal data, but it is only aimed to confirm basic information.[331] Promoting data linkages with other ministries and agencies will enable the Election Commission to ascertain unregistered eligible people, but the commission takes a stand that voting in elections is a right and that people should do the registration by themselves.[332]

(3) Census

Malaysia conducts a census once in 10 years.[333] Individual data collected in the population census are shared by ministries and agencies, which extract and use necessary data. Data related to the elderly and social security are included not only in the census data but also in the data of the household budget survey which is conducted twice every five years.

Some census data are shared with the NRD. Basically, however, the Department of Statistics and the NRD handle their own data separately and do not share data actively.

In the household budget survey, enumerators visit each home and collect data. Enumerators are employed specifically for the census for one or two weeks with the cooperation of the head of each local government. Collected data are monitored and checked by responsible officers of each district. The Department of Statistics has local offices in each of the 40 states.

6.5. Situation of Other Grant Benefits Including Food and Fuels

(1) Food Baskets and Feeding Programme

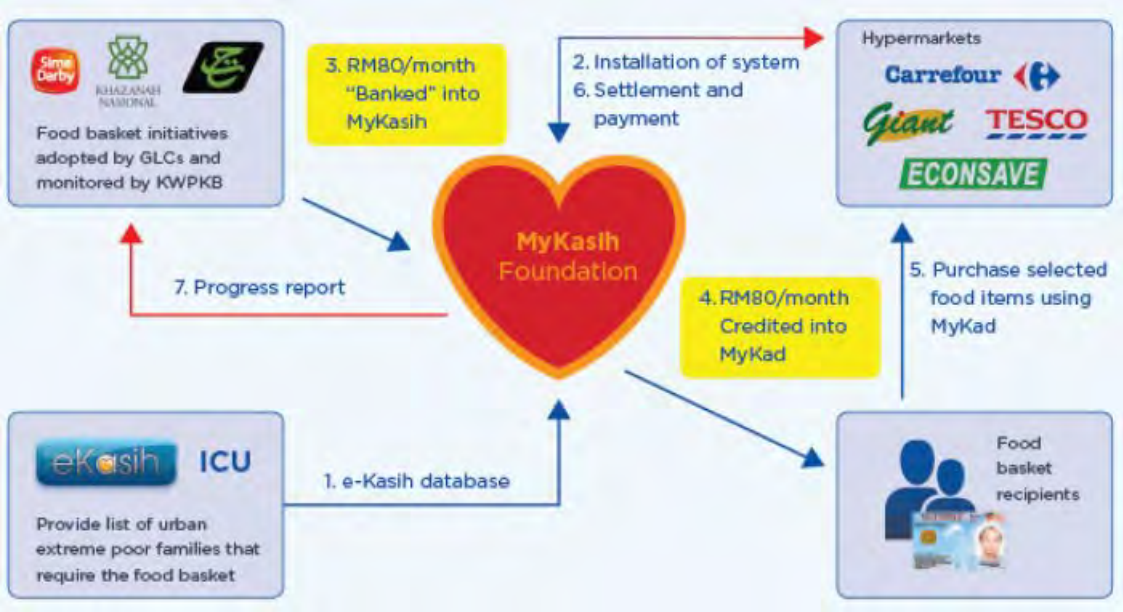
In the Government Transformation Program strategies to raise the living standards of low income households, the food basket and feeding program initiatives have been highlighted. This is due to the high financial constraint on the urban poor who spend 40% of their income

[329] On-site hearing survey on March 18, 2013 (Election Commission）
[330] On-site hearing survey on March 18, 2013 (Election Commission）
[331] On-site hearing survey on March 18, 2013 (Election Commission）
[332] On-site hearing survey on March 18, 2013 (Election Commission）
[333] The descriptions that follow are based on the on-site hearing survey on March 19, 2013 (Department of Statistics）.

on food and beverage, as compared to other necessities.

1) Urban communities

This initiative addresses the high portion of household income that the urban poor spend on food. The food basket programme will leverage the MyKasih Foundation by adopting its cashless aid where needed. Recipients identified by ICU under eKasih system will receive a monthly contribution of MYR 80 stored in his or her MyKad to be used to purchase essential food items. The distribution network will see the food aid programme to distribute involvement of several hypermarkets that have wide coverage in urban areas, such as Giant stores, Econsave and retail shops potentially under the TUKAR (Change) programme established under the Economic Transformation Programme.



Source: Government Transformation Program Annual Report 2011. [334]

Figure 6-2 Process Flow of Food Basket Initiative

2) Indigenous Communities [335]

The Ministry of Health presently helps Indigenous Communities by distributing a MYR 150 food basket per month for malnourished children between six months to six years of age. In the past, Indigenous Development Department (JAKOA) also provided a MYR 200 food basket per month for the hardcore poor and poor families on an ad-hoc basis. However, this has been discontinued due to budget constraints and changes in policy. Two enhanced initiatives have been identified to reduce malnutrition among interior indigenous children by

[334] PEMANDU, (2011). "GTP Annual Report 2011, Raising Living Standards of Low Income Households".
[335] PEMANDU, (2011). "GTP Annual Report 2011, Raising Living Standards of Low Income Households".

25% in 2015 through a rehabilitation programme.

Components of the food basket are:

Rice vermicelli (3kg)

Full cream powdered milk (2kg)

Sweet biscuits (3kg)

Fish sardines (7 small tins, 155g/tin)

Cooking oil (1kg)

Multivitamins (30 capsules)

Special Milk (800g, 400g/tin)

7. Analysis of Aging in Malaysia and a Proposal for Areas in which Japan can Cooperate

7.1. Current situation and issues in Malaysian policies regarding aging

(1) Policy framework for an aging society

Issues of aging in Malaysia have been recognized by the Malaysian government as a long-term policy objective since the necessity of such policy was noted in the Tenth Malaysia Plan. Programs for the elderly are also noted in each stipulation for public services, including housing, income security, and health and medical services. The primary focus of the aging policy is the idea of “active aging,” where the elderly are considered as active and productive members of society, and are given support in order for them to fulfill their social obligations.

In addition, policymakers from government agencies are very well aware of the utilization of social capital, including NPOs, and are aggressively incorporating a concept of “Aging in Place,” as adopted by the advanced aging countries. The actual services considered involve the construction of a system based on individual homes and on community. Such fundamental ideas are widely shared and held among government officials concerning policies for the elderly, and this fact shall be well received.

On the other hand, issues are mounting. The National Policy for the Elderly and the National Health Policy for Older Persons have been proposed as specific policies by the Ministry of Women, Family and Community Development and the Ministry of Health, respectively. This means that the policies considered most central to aging have been proposed by two government agencies, while no specific policy that integrates them is existent. Due to the lack of an integrated legal system and policy system, each government agency individually implements its programs, from which hierarchy among government agencies becomes the issue. It is considered that an integrated roadmap to the aging policies with a medium- to long-term viewpoint is lacking. However, regarding this issue, with PEMANDU as the leader, various agencies including the Ministry of Health, Ministry of Women, Family and Community Development, and EPU have started to work to introduce an integrated piece of legislation regarding elderly care. The results are expected in the future.

The approaches taken by each government agency consist of various types of programs implemented based on progressive views. However, financial backing to implement planned systems/services and the sustainability of such has not been ensured sufficiently, and such financing would be influenced by the yearly budget secured by the Ministry of Finance. In addition, the budget for each program is small, thus the issue has not come out of the trial

stage in terms of a ripple effect for the entire nation.

This indicates that policies for the elderly are not focusing on the points. In order to concentrate capital investment on specific issues, it is necessary to specify and prioritize such issues, and this requires data management and analysis. Academic institutions such as the UPM are implementing various types of research and investigation projects. However, despite this, the results of those research and investigation projects are not well reflected in the distribution of capital, leading to a situation where no strategic investments are performed.

(2) Constructing an elderly care system based on a limited social security system

In Malaysia, EPF is provided as an income security system for the elderly, and many of the employees of private companies subscribe to it. It differs from the Japanese National Pension Plan in that it basically uses an individual account with a contribution method. In addition, sickness, death, and disability are compensated under the social security system known as “SOCSO,” and this is separate from the elderly income security system. EPF is characterized as a publicly backed savings system rather than a social security pension benefit system, and benefits (withdrawals) over the contribution amount are not allowed. Therefore, this is a limited plan as an elderly income security system in terms of the period of social security. In addition, the characteristics of the contribution plan allow for the insured to withdraw his/her contribution before he/she reaches old age, making it not exactly an income security system for the elderly when they reach actual old age. This is an issue of this system.

In addition, regarding health insurance, a health care system through a tax-based system is organized, and health care services can be received at low cost. However, a private health insurance market also exists, and in reality, the public health care services are for the low-income class. This creates an issue of a gap between private medical services and public medical services.

Currently, while the Malaysian government implements incentive policy aimed at strengthening the staffing for public medical services, it also considers the introduction of social insurance system and sustainable medicare system from the long-term perspective.

(3) Current situation and issues in the development of Elderly services based on community

Services for the elderly at community level have been promoted by NGOs playing the leading role, although this is limited to certain areas. The Malaysian government (Ministry of Women, Family and Community Development) is currently organizing and promoting a Home Help

Service and Day Care Service (Activity Center) as a focused elderly care service for those living at home. The Home Help Service is provided through a service that takes care of the mildly impaired that require support for IADL, by taking them to hospitals and by shopping for them, along with providing physical support for the bedridden elderly. However, the service users number around 1,600 nationwide, and service providers are limited to four organizations (NGOs) except for the services provided directly by the government. Therefore, this approach is still in the stage of a model program and will take more time to disseminate nationwide.

On the other hand, the Day Care Service has been organized and aimed nationwide at 22 day care centers run mostly by NGOs, intended for respite for caregivers and rehabilitation training for care receivers, where services targeting the elderly requiring certain care have been provided. However, this was run without transportation services, making it difficult for those with limited mobility and without transportation to use the services, resulting in a low rate of service use. Consequently, starting in 2012, the centers were renamed as “Activity Centers,” and the services provided were changed to preventive care services involving community activities intended for the elderly who are more self-sufficient. Centers referred to as “Activity Centers” are limited to 22 locations, which receive subsidies from the government, but it is considered that there are many other small community activities that offer similar services nationwide. Many of those non-profit activities are run without government funds, and their actual conditions are not fully understood. In addition, since 20 out of 22 locations are run by the same organization, in order to expand services, over the medium-to-long-term period, financial aid shall be given to various regional operating bodies to broaden the width of the service providers.

The reason why “Day Care Services” were converted into “Activity Centers” can be considered an idea based on providing highly effective services with limited resources, but this does not mean that the day care service needs of care receivers at home have diminished. Therefore, how to support care receivers at home in the future should be re-examined in new studies.

In organizing the elderly care service, the Ministry of Women, Family and Community Development specifies that services shall be community based, informal resources including volunteers and mutual support among the elderly (active aging/successful aging) shall be fully utilized, and that home care service shall be the principle. These approaches are expected to be the core of the policies for an active elderly with the aim at elderly working and participating in society.

However, a specific and strategic roadmap, including obstacles and priority orders for capital investment in the organization and promotion of services in the future, is not necessarily clear. Additionally, aging and an increase in the number of care receivers have been each proposed as the background issue, but regarding how social and economic disadvantages, in case these issues are left unsolved, would emerge has not been fully studied and not shared among government officials. From now on, it is required that the concerned parties share their views on how to perceive the aging issue as a social problem and how to draw a blueprint for community-based care systems fully utilizing limited resources.

(4) Current situation and issues regarding residential care

The Ministry of Women, Family and Community Development manages RSK at nine locations and RE at two locations nationwide as residential care centers for the elderly. These facilities are primarily for the low-income class, and RSK takes in self-sufficient elderly while RE focuses on the elderly who need medical care. However, as to RSK, it is not positioned as a universal service, as homeless elderly people are judged by the court to be admitted there.

In addition to those public facilities, privately run elderly service facilities have recently been organized and promoted. These private facilities are divided into those that complied with the standard (*Care Center Law*) set by the Ministry of Women, Family and Community Development and registered, with the others not meeting the standard. In addition, the Ministry of Health separately sets the standard based on private health and medical care service laws, and medical-related facilities meeting this standard exist. Consequently, the level of the provided services is not standardized.

In Malaysia, basically, elderly care is supposed to be provided at home. Despite this, some elderly care facilities are expected to be organized in the future with the increase of middle-income earners. However, as the government doesn’t have the intention to promote the development of facilities and welcomes the development of those facilities by private capital, most of them are expected to be organized and run by private capital and NGOs. The NKEA (National Key Economic Area), defined in the Tenth Malaysian Plan, specifies private health care as one of the priority areas, along with tourism, education, business services, and agriculture, and the government is supporting this trend.

The Malaysian government made it a national policy to become a high-income country by 2020, and it is expected that the middle-income class will increase. This would be the class of society who would purchase facility services run by private capital. Regarding when facilities

are being organized as a free-market service, whether the quality of life of facility users will be ensured will be one of the issues to be tackled in the future.

Meanwhile, the government, based on the 1MFC policy, ordered the Ministry of Health to consider and advance legislation as to the integration of elderly care facilities, and this is positioned as the priority issue to be taken care of by the Ministry of Health. It is possible that the standardization of the level of services would be advanced when facility functions are organized and when rules on residential care facilities for the elderly are organized under these approaches.

Notably, as to facilities for the elderly, those facilities regulated by the *Care Center Act* under the jurisdiction of the Ministry of Women, Family and Community Development and the others regulated by the *Private Health Care and Medical Care Service Act* under the jurisdiction of the Ministry of Health coexist, and, in addition, private facilities not meeting the standards set by those laws are increasing. From the perspective of increasing private facilities and ensuring the quality of such, the organization of legislation and specific measures are needed for consideration about various regulations.

(5) Issues in aging policies

The common issues with regard to aging policies can be summarized as follows.

First of all, the priority issues and roadmap for future elderly care and social security system are not clear. In other words, the issues regarding when aging would progress in society are not yet clarified in various areas, including economy, community, social security systems, and sustainability. Each policy aims to please everyone so far, thus a strategic roadmap must be implemented in terms of “Why should that policy have priority?” As a prerequisite, policy consultations are important to reconfirm the consistency of National Policy for the Elderly and National Health Policy for the Elderly, which are adopted as the policy frameworks.

Second, implementation of thorough assessment of the individuals and community is necessary. Though academic institutions have the data related to the living condition of the elderly, more time is needed to collect data that can be used for more detailed analysis.

Needs and scale have to be clarified through the analysis and classification of the issues related to support needs of the elderly and their qualitative differences, based on the results of quantitative research. This work will contribute to set the priorities for issues on aging society in Malaysia.

Thirdly, with regards to each service, communities and organizations that receive public support are limited, and quantitative expansion will still take time. Even in advanced

countries, new service developments take time to research, develop, and implement for any model program, but the nationwide adaptation afterward is a prerequisite. As in Malaysia, the design of infrastructure intended for the universalization of services and sustainable financial backing are necessary.

If the Malaysian government chooses to adopt a policy to promote services provided by private capital in expectation of expansion of the middle class and their improvement of purchasing power in addition to quantitative increase of services, the Malaysian government should adopt policies to promote service provision by private companies for the sake of respecting the dignity of the elderly and developing the institutional framework. This would include things such as certification and regulation regarding the content and quality of services provided by private companies.

7.2. Potential cooperation by Japan

(1) Potential cooperation regarding social security systems

In Malaysia, the basic designs for EPF, the income security system for the elderly, SOCSO, the social security scheme for employees, and the public health security system funded by taxes, have been implemented, and they are already in operation. Regarding the health security system, arguments about the provision of universal coverage through the introduction of a social insurance system have already begun, but no specific renovation plan has been made. Therefore, it is considered that the need for system design is current is not a high priority issue for cooperation.

The Malaysian social security system is essentially different from the Japanese system in terms of securing a source of funds and the basic approach for designing such system. As to the improvement of individual schemes, it is more suitable to compare them with systems in Europe or neighboring Thailand or Singapore, where similar systems have been introduced.

This research indicates that Malaysian government officials have a strong interest in the Japanese nursing care insurance system. However, the Japanese nursing care system depends on the national health insurance system under the social security system for securing funds, and it is difficult to transfer knowhow directly. In current-day Malaysia, where the elderly income security system is not universal, discussion of funding sources is a critical component of the future sustainability of Malaysian care service. However, information on the Japanese nursing care system and medical system for the elderly shall be introduced only to be compared with the Malaysian social security system in case Japan would like to proactively respond to a Malaysian request for information on the Japanese nursing care insurance

system.

(2) Development of basic information infrastructure of measures for the elderly

The development of an information database on living conditions of the elderly is necessary for the policies affecting the elderly. With regard to development of needs-oriented services and institutions, it is essential to ascertain in as much detail as possible the living conditions of the elderly, such as their physical and mental condition and household type. Inter alia, Malaysia is a multi-ethnic country where each ethnic group has its own views on family, and life and death. Though academic institutions have this type of information based on their own surveys, most of them are one-off surveys. Establishment of a fundamental information database about the elderly based on periodic national level surveys is necessary, and this raises the question of which information should be collected in time-series.

In Japan, periodic surveys that enable comparative time-series analysis were implemented before the long-term care insurance system was introduced. With regard to long-term care insurance, Long-Term Care Insurance Business Status Report, Long-Term Care Service Facilities and Offices Survey, and Nursing Care Business Management Survey have been conducted. The National Livelihood Survey has been conducted nationwide to obtain information on lives of the elderly. Additionally, local governments have conducted regular surveys, on issues such as life sphere needs assessments, in order to ascertain the living conditions of the elderly. In recent years, the Japanese government has integrated those surveys and disclosed information for more diverse analysis and evidence-based policy making.

Adopting a medium to long-term roadmap and strategy on aging policies is an important issue in Malaysia, and it is useful to develop fundamental information infrastructure for objective policy making. Development of these measures should be carried out by the government through joint development with highly experienced academic intuitions. Public research institutions, such as the National Institute of Public Health and universities, Ministry of Internal Affairs and Communications of Japan, and Ministry of Health, Labour and Welfare are assumed to be the most appropriate cooperation partners.

In addition, ascertaining the basic needs will be a source of basic market information for private companies and promote quantitative expansion of services. Provided that private companies become the main service provider for the elderly, information of those needs will be important clues for them to develop new services and consider their entry strategies.

(3) Possibility of cooperation on policies for the independent elderly

The activity center is the measure that provides services not for the dependent elderly and

the frail elderly but for the independent elderly in order to promote their social participation. This goes along with the stance of the Malaysian government which emphasizes that the elderly themselves should utilize their own abilities and participate in society.

After the post war period, the Japanese government developed the environment and facilities nationwide for providing recreation for the elderly, such as clubs, welfare centres, and house of relaxation. In recent years, because of changing times and diversification of values of the elderly, the place of cultural exchange extends to various private activities and volunteer activities. Though the number of public facilities providing recreation has decreased, local governments continue to provide activities for the elderly and they contribute to the improvement of the elderly's health.

Silver Human Resource Centers, which undertake light work for a short period of time in the communities, have been established nationwide and expected to be bearers of life support for the frail elderly. Declining birthrates and population aging have activated the development of various measures, such as elder care services by the elderly and the launch of community-based business. Sharing those experiences will be beneficial for Malaysia.

Health improvement of middle and old aged people and NCD measures as a premise of social participation are areas where Japan can provide cooperation. In particular, mass screening carried out by the local government and health diagnosis in the workplace have contributed to the early detection and treatment of NCDs. In recent years, the Japanese government set "Healthy Japan 21" as a national strategy and measures for metabolic syndrome and guidance for improvement of lifestyle have been carried out nationwide.

Cooperation on policies for the independent elderly may include case studies of those efforts to the central and local government officials and NGOs in Malaysia. In Thailand, fostering health volunteers is thriving, and more than 1 million volunteers have contributed to the solution of health problems in local communities. Providing the opportunity to learn the efforts of ASEAN countries through training is an effective way of improving care services for the independent elderly in Malaysia.

(4) Possibility of cooperation on the development of the community based elderly services

As shown in 1MFC, the Malaysian government intends to systematize services for all residents having life issues in communities. This matches recent international trends, such as integrated care and aging in place, being actively discussed in Japan and European countries. Moreover, as it is also consistent with Community Based Integrated Care System and "the principle of precedence on home care" represented in the Long Term Care Insurance Act. This is an area where Japan can promote cooperation.

Recently, the Japanese government has strengthened "community-based service," and

introduced new services in order to promote residential care. Moreover, HHS provides daily support (support for housework) and physical care service. In recent years, new integrated services of care and nursing care are being developed.

The number of day care centers has increased most among the services since the introduction of the nursing care insurance system, and they range widely from preventive approaches for self-sufficient elderly in ADL to services for the most critical care receivers. The contents of such programs are diverse, thanks to the efforts by private program organizers.

Regarding facilities, various kinds of facilities, ranging from public facilities including nursing homes, intensive care nursing homes, and health care facilities for the elderly to private retirement homes and group homes, have been researched, developed, and organized. Recently, residence-style care facilities and the expansion of facility services through communities have been advanced. This is a change of direction in facility organization in accordance with home care service organization—this has been a historical moment.

The Japanese home visit care system has been evolving since the 1960s, over a long period of time. This “over the long term” progress in the Japanese home visit care system should contribute to the adoption of a road map for the medium- to long-term service development and promotion plan of private companies into the care sector in Malaysia.

However, transfer of the experiences of Japan does not necessarily mean transplant of individual services developed in Japan into Malaysia and sharing successful experiences.
In the Japanese Home Help and Day Care Service, priority was initially placed on quantitative expansion at the launch of the system. This caused delay in fully providing the physical care services necessary for care receivers to stay home, as the focus was on life support service rather than physical support service, and the importance of rehabilitation training was overlooked as a result of the focus set on the respite feature of day care service. This should be kept in mind.

Regarding the upgrade of residential care, the development of social hospitalization [336] at geriatric hospitals since the 1970s and the launch of rehabilitation facilities for the elderly [337] intended that care receivers come back home, but demonstrate a history of trial and error. Cooperation based on lessons learned in Japan will play an important role in long-term

[336] This means the state of long-term hospitalization in medical institutions because of insufficient support for home care though medical need is low.
[337] This means intermediate institutions that provide rehabilitation in order to prepare for home care after discharge from general hospital, including the acute phase. This was introduced by the amendments of Law of Health and Medical Services for the Elderly in 1987 aimed at the elimination of social hospitalization.

service development in Malaysia.

Upon this historical background, it is difficult to transfer the experiences of care services development in Japan directly to Malaysia. It is important to convey both sides of the success and failure as well as the cultural, social, and historical contexts of policy development in Japan. It is also important for Japan to take the cultural, social, and historical contexts of Malaysia into consideration. Having a certain amount of time to hold seminars, training, and policy consultation is important to enhance mutual understanding between two countries. Deepening of mutual understanding raises the cooperation level from information exchange to development and implementation of specific model business in Malaysia.

It should be noted that cooperation in designing and developing services not only may become a major source of information for government, private companies and NGO in care sector, but also may become a trigger for the development of new services that meet the needs of Malaysia. Therefore, it is important to involve the private sector in the cooperation of service development.

(5) Potential cooperation in terms of the improvement of care service quality

In addition to such overall strategic designs for service organization, Japan can play a cooperative role in the standardization of individual services. Nursing care services provided under nursing care insurance in Japan are regulated not only for structures such as facilities and personnel, but also, to some degree, for service processes. Moreover, and the contents of services provided are standardized.

Most of the care services in Japan are provided by private organizations, and the standardization of services provided in accordance with the compensation system and subsidy system has materialized with regulation by the government. Flexibility of profession may be restricted if the services provided are excessively regulated and the services become uniform. However, introduction and implementation of appropriate regulations and criteria are effective methods when standardized services are provided nationwide.

Development of regulatory measures by the government is a big issue. Cooperation between the Ministry of Health, Labour and Welfare of Japan and regulatory agencies of Malaysia will be beneficial for Malaysia.

With regard to quality improvement of care on-site level, the evaluation system including assessment, care management, and the Certification of Needed Long-term Care for care receivers is still in a trial-and-error stage in present-day Japan, but it will be of great use for the improvement of infrastructure in policy studies in Malaysia.

Moreover, scientific and empirical knowledge have been accumulated from the abundant

on-site care service experiences gained over a long period of time, regarding effective care in each profession and the method used to prevent the elderly from becoming regular care receivers. These shall greatly contribute to the standardization of care services in Malaysia.

By transmitting experiences and lessons accumulated on-site to the government, professional, and service providers through lectures, quality of service will improve.