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# Systemic Resilience and Carework: An Asia-Pacific Perspective

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As we enter the year-2 of the COVID-19 pandemic, it has become all too obvious, even a cliché, to say that the pandemic has exposed the importance of care and carework and how our economies and social functioning depend on the invisible work of care. We have seen a large number of older people, particularly those in long-term care homes, die as the result of lack of care; too many frontline workers catching and succumbing to COVID infections from workplaces; and parents stressed as they multi-task paid work and childcare at home. As we begin contemplating the post-COVID future, policy conversations are beginning to focus on pathways to recovery and systemic resilience. Systemic resilience refers to the potential or ability of social and economic systems to rebound after endogenous or exogenous shocks, and COVID-19 may be one of the most momentous shocks the world has shared in the last generation. A huge systemic shock can crack open social and economic fault-lines leading to disruptions and collapse of functions that cascade down the social and economic chains—as COVID seems to have done—but it also creates openings for change. A resilient systemic response must capitalize on these openings to rebuild.

In this think-piece I consider how we can build a resilient systemic response to the COVID-19 pandemic and future crises. I focus on systemic resilience in relation to carework and global migration of careworkers,[1] and I approach this from an Asia-Pacific perspective. One of the fault lines exposed by the COVID-19 is the vulnerability of the existing care, carework and migration infrastructure to exogenous shocks. Asia-Pacific is an important site to examine because it is one of the major sites of global care migration, both as sender and receiver of migrant careworkers. This think-piece draws on the research from our global partnership project based at the University of Toronto, which looks at the dynamics of careworker migration in Asia-Pacific and the interconnections between social and economic forces and policies in shaping those dynamics from both sending and receiving country perspectives.[2] The next section briefly outlines the pandemic's impacts on carework and care migration in Asia-Pacific. I then discuss how we might achieve systemic resilience in global care migration by first emphasizing how our care systems are interlocked with the global migration of careworkers (what I call a global care interlock), and second, how we might achieve systemic resilience. Understanding the global care interlock is an important prerequisite to systemic resilience because it allows us to see carework and migration of careworkers as a part of a larger global infrastructure or ecosystem that has been, consciously or unconsciously, built, managed and sustained by multiple actors in different parts of the globe.

## The impacts of COVID-19 on carework and migration in Asia-Pacific

There is now ample evidence confirming the unequal impacts of the pandemic. Global and national studies show that women, people of colour, Indigenous people, immigrants and low-income families have been disproportionately and adversely affected (CDC, 2021; Public Health England, 2020; Public Health Ontario, 2020; UN Women, 2020). This is in part because they are more likely to work in occupations that require direct in-

[1] I define care as work (both paid and unpaid) and relationships that are necessary for the health, welfare, maintenance and protection of all people, young and old, able-bodied, disabled or frail. In this piece, I focus primarily on paid carework. Careworkers refer here to people who provide direct-care services, including front-line careworkers, personal-service workers, nannies and domestic workers.

[2] For more information on our research, please see: https://cgsp-cpsm.ca/

person contact, such as care and domestic work, accommodation, and food services, and therefore are more likely to be exposed to the coronavirus.[3] While the global demand for front-line careworkers has increased, a large number of women in other low-wage service-sector work (e.g. accommodation, food services) have been unemployed or furloughed because these sectors are amongst the first to be closed down due to COVID lockdowns (UN Women, 2020). In the USA, the rates of age-adjusted COVID deaths amongst Indigenous, Black and Latino peoples are more than twice that of the White population (AMP Research Lab, 2021; CDC, 2021). The situation is much the same in Canada (Allen, 2020; Etowa and Hyman, 2021; Public Health Ontario, 2020). In the UK, too, COVID-19 case and death rates are significantly higher among Black and Asian populations than White population (Public Health England, 2020).

As more data highlight gender, race and class inequalities exposed by COVID-19, migrant workers still remain relatively invisible . Migrant workers are hugely affected by the global pandemic, yet still little is known about these effects, particularly those affecting female migrant workers. This is partly because data are both scarce and difficult to collect, and partly because many migrants, particularly women, work in private homes or are confined to workplace dorms and therefore have restricted access to public spaces or outside contacts. Our research focuses on migrant careworkers, most of them women, in the Asia-Pacific region.[4] Asia-Pacific is an important region to study because it has the world's largest population (4.6 billion people—60% of world's population; UNESCAP, 2020). With about 93 million international migrants (34% of global migrant stock) in 2019 (UNDESA, 2019)[5], Asia-Pacific is the world's largest supplier of foreign healthcare and careworkers, and the largest recipient of care and domestic workers.

Our research finds that COVID-19 had, and continues to have, tremendous personal, social and economic impacts on migrant careworkers. It has often further restricted the little mobility that was available to them. For example, we have received reports about migrant careworkers being confined with the patients and elderly people they care for: during the COVID-19 lockdown in Wuhan, China, many long-term care institutions closed their doors and locked the residents and direct-care workers, most of them migrant women from rural regions, inside. These workers had to make temporary sleeping arrangements in the staff room and eat food that was brought in through the barrier door. In-depth interviews with these workers conducted by one of our research associates found while many were fearful of contracting the virus and stressed by the 24/7 total confinement, they nevertheless continued to care for their frail elderly care recipients out of a sense of commitment, obligation and resignation (Yan, 2020). COVID-19 has worsened working conditions and compromised personal safety and mental health with migrant careworkers at increased risk of contracting coronavirus because so many of them care for older people who are themselves at risk of getting sick.

Elsewhere we hear about foreign domestic workers confined to the house to care for the sick or required to take on more work to comply with employer demands for more rigorous cleaning regimes, extra precautions in food preparation, and more personal care services, or who were laid off, faced pay cuts, or given less food because of changes in their employers' financial situations (UNESCAP, 2020). In May 2020, only a month after the Singaporean government imposed a "circuit-breaker" lockdown, the Singapore-based NGO, Humanitarian Organization for Migration Economics (HOME), reported a 25 percent increase in the number of distress calls from foreign domestic workers reporting overwork, verbal abuse and inadequate rest (HOME, 2020). Similar reports of mobility restrictions, increased workload, and mental health concerns among foreign domestic workers were also found in Hong Kong during its circuit-breaker periods (Summers, 2020). Most migrant careworkers live with their employers as a part of their labour contract and immigration status, and the inability to leave their employers' homes during the COVID-19 lockdown added to stress and social isolation and also exposed them to potential violence and abuse. There are reports of increased employer surveillance and control of foreign

[3] Other factors contributing to the COVID-19's adverse impacts on these people and families include such non-employment factors as overcrowded and poor housing conditions, the high cost of housing, lack of access to healthcare, lack of information, etc.

[4] While migrant workers are involved in all sectors of economy, including health care, construction, manufacturing and agriculture, here I focus on those who are involved in care and domestic work. I refer to care and domestic workers as 'careworkers' because a significant amount of domestic work involves caring for children, the elderly and other people.

[5] Asia-Pacific region is defined here as the region that includes all of Asia and Oceania.

domestic workers in Singapore (Antona, 2020). Reports from the Middle East, one of the largest destination regions for female migrant workers from the Asia-Pacific, also note in addition to increased work demand and wage cuts, heightened risks of gender-based violence faced by foreign domestic workers (Aoun, 2020; UNESCAP, 2020). Many who became unemployed or hoped to return home to care for their own families have been stranded due to travel restrictions and border closures.

The pandemic has also had serious impacts on sending countries. Migrants' job losses and/or income reductions translate to falling remittances and household incomes. For many countries in the Asia-Pacific, the impact of decline in remittances on the national economy can be devastating. The Asia Development Bank estimates that, worldwide, global remittances will drop by about $57.6 billion (9.7%) in 2020 as a result of COVID. Of this, the Asia-Pacific region will see a decline by $31.4 billion (or 11.5% of baseline remittances to the region in 2018), and in the case of Asia, about 54% will be lost from the Middle East (ADB, 2020), where a large proportion of Asian migrant women work as foreign domestic workers. This means that many dependent families will have less money and in some cases may plunge into poverty. For countries such as Nepal, Pakistan, the Philippines, and Sri Lanka, where remittances from migrant workers overseas make up 23%, 9%, 9% and 8% of their total GDP, respectively, a drop in remittances of even a few percentages means a significant dent in the national economy. National governments will have less income to fund services, thus delaying or even reversing national economic development.[6]

COVID-19 also affects receiving countries. Shortages of essential workers in key sectors such as agriculture and health care—sectors where a large proportion of migrant workers are employed—have forced national and sub-national governments in high-income countries to make changes and concessions to immigration, employment and other policies in relation to migrant workers. In Europe, some governments have extended work visas, made exceptions to travel bans, and/or granted temporary status to migrants if they work or will work in essential sectors (Anderson, et al. 2020). In Canada, with over 80% of COVID-related deaths occurring in long-term care homes, severe careworker shortages have led the federal government to call in the army and forced some provincial governments to take drastic measures. These include establishing paid training programs for long-term careworkers with assured employment plus a COVID-emergency wage premium upon obtaining a certificate; and inviting domestic and foreign students, unemployed, immigrants, and refugees and asylum seekers to take the training (Canada-National Defence, 2020; CBC, 2020).

**Towards systemic resilience in global care migration**

In order to achieve systemic resilience in global care migration, we need to first recognize how care, carework, and the migration of careworkers are interlocked in a global system. Like other commodities, care has a global supply chain, but instead of manufacturing parts, this chain involves a chain of people (mainly women) in different parts of the world providing essential care services. For example, a middle-class working mother in a rich country hires a Filipina nanny to care for her children; the nanny in turn hires a local nanny to care for the children she left behind in the Philippines; that local Filipina nanny leaves her children or ageing parents in the care of her siblings in exchange for money or support, or even for nothing; thus forming a systemic interlock (Hochschild, 2000). This stems from a combination of demand for careworkers in high-income countries, the low value given to carework, and economic inequalities within and between high- and low-income countries which pushes women from low- to high-income countries.

Contributing to this system's interlock are other individual and organizational actors, including, businesses (recruitment and employment agencies, migration intermediaries, etc.) and government institutions (e.g. Philippine's Overseas Employment Administration, Canada's Foreign Caregiver Program, Japan's bilateral Economic Partnership Agreement (EPA) for nurses and careworkers), all of which sustain and shape types of

[6] At the individual/household level remittances allow families in sending countries to increase their private household consumptions, savings and investments; at national level, they are an important source of foreign currency for the sending countries, allowing them to offset balance of payments, and in some cases also invest in economic development. Some countries (e.g. India), impose tax on inward remittances, however many countries (e.g. Vietnam and the Philippines) have removed the tax because they discovered that removing the tax actually increased inward remittances through formal channels (World Bank, 2017).

migration, who migrates to where, migration trajectories, etc.— in short, the global care interlock.

The global care interlock tells us that care links us globally, and increasingly across continents. Adverse impacts of COVID-19 on migrant careworkers and desperate measures introduced to secure essential careworkers demonstrate that, tight as this interlock may be, it is not working—indeed it simply crumpled under COVID, intensifying the global care crisis. The existing global care interlock is not resilient; it became paralyzed by COVID lockdowns and border closures, and the cascading impacts of such systemic paralysis on the social and economic wellbeing of people in both sending and receiving countries have been disastrous.

To make the global care interlock more resilient, we must change its main operating principles from efficiency and cost-effectiveness to flexibility and innovation (OECD 2020). To achieve the former, the infrastructure has been left bare-bones lean: employers hire migrant careworkers because they are cheaper than native-born workers; receiving country immigration policies favour "high-skill" workers, yet many of them end up working in low- or semi-skilled jobs[7]; and sending country governments encourage the out-migration of their young workers because remittances generate quicker returns than investing in long-term social and economic development infrastructures. This has made each segment of global care interlock highly dependent on the other, and when one segment gets stuck, the entire system becomes paralyzed, thus turning efficiency on its head. We need to rethink this model.

There is a growing agreement amongst economists and policymakers that in the long run, the traditional efficiency-driven approach is undesirable, not only because this race-to-the-bottom or race-to-the-lowest-cost thinking is inconducive to global development, but also because when such a system encounters a shock like COVID, it simply cannot absorb and respond efficiently (OECD, 2020). A smarter approach would be to build local and national care capacities (some economists may call this "redundancies") in both receiving and sending countries, so that countries are less dependent on the existing system of global careworker pipeline. Building local and national care capacities will mean investing in human capital and social infrastructures for care, including more standardized and better training and even certification for careworkers. This will add to the cost of care and carework; but the trade-off will be revaluation of carework and better wages and working conditions for careworkers, more local and national citizens attracted to work in the sector, and expanded size and quality of care workforce. In short, better quality care and less dependency on global careworkers supply chain. Investing in local care capacities, however, does not mean total rejection of global careworker migration. As populations in both sending and receiving countries age and ideas about care change, global demand for careworkers will continue grow, and migrant careworkers will still be needed. Investing in human capital and social infrastructures will help raise the quality of care and increase and diversify the supply of careworkers, thus making the global care interlock more flexible in responding to future shocks.

This will also demand a multilateral accord requiring both receiving and sending countries to adhere to basic labour standards for and treatment of domestic and foreign care workforces, including recognizing training requirements and certification, wage levels, and employment standards for both domestic and foreign careworkers. A multilateral accord might look something like Japan's Economic Partnership Agreements (EPA) for careworkers with Southeast Asian countries, but that allows for different skills levels ranging from domestic work to more skilled health-care work, and organized at regional or global level.[8]

Can we pay for this? I believe there are some signs of positive political support for social investment in care. The

[7] There is a large body of research on immigrant skills mismatch. In North America immigrants are more likely to have higher educational level than their native-born cohorts, yet they are more likely to have low-wage, low-skilled jobs. In the US, immigrants aged 25+ working in the healthcare sector are more likely to hold a bachelor degree or higher than their native-born counterparts, particularly those working as home health aides, personal care aides, and nursing assistants (MPI 2020). In Canada, nearly 60% of Live-in-Caregivers (about 90% of whom were from the Philippines in 2011) have bachelor or higher degree (Banerjee et al. 2017).

[8] Japan currently has separate bilateral EPAs for careworkers with the Philippines, Indonesia and Vietnam. These EPAs have been criticized for restricting the intake of foreign careworkers as it requires EPA careworkers to pass Japanese licensing examination (in Japanese) within three to four years. However, it also has been recognized that the EPA ensures wage and employment standards and a pathway for long-term residency.

recent passage of $1.9 trillion COVID relief bill by the Biden administration in the US, and the administration's commitment to appropriate $775 billion for childcare and education and $450 billion for elder and disability care over ten years, and the Canadian federal government's renewed commitment to creating a nationwide early learning and childcare system, all in response to the COVID-19 pandemic, seem to suggest that the time may be ripe for transformational policy changes.

Admittedly, this proposal is a long-term strategy. But the COVID-19 pandemic has opened doors to take action. The first step is to use this moment to rethink the value of carework and reconfigure the global care interlock. The first concrete action would be for governments to set new wage and employment policies for careworkers and develop a more collaborative regional or global system of care migration. Already many governments have implemented COVID-wage premiums and made changes to employment regulations to improve the working conditions of careworkers, domestic and migrant. As well, some governments are revising their immigration and skills training policies to secure more careworkers. We must make sure these measures will continue after COVID.

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