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Conceptualizing Transnational Migration of Care Workers: Between "Skilled" and "Unskilled"

Reiko Ogawa

Summary
The demographic change, resulting from a low fertility rate and an aging society, has led policy makers and business sectors to rethink Japan's future population prospects. Although Japan has been considered an anomaly among the industrial democracies in not depending on foreign labor to pursue its economic goals, the acceptance of highly skilled migrants is being discussed as one option to cope with depopulation and maintain Japan's economic growth strategy. In line with immigration policy, migration of nurses and care workers from Southeast Asian countries started in 2008 upon the establishment of Economic Partnership Agreements (EPA) between Japan and the Philippines, and Japan and Indonesia. The migratory framework was shaped by professional organizations in a way that protects the domestic market and working conditions, and it mandates that the migrants pass the national exam on nursing and caregiving within a certain period of time. This paper will elaborate the policy factors that either enable or hinder the movement of nurses and care workers to Japan under the EPA, especially focusing on the skill of care workers three years after its implementation. Although the EPA theoretically opens up a path for migrants to work under the same conditions as Japanese once they pass the exam, in practice the skills of care workers have often been contested. How Japan defines care work and how it incorporates migrants into the care regime will shape Japan's future immigration policy, labor policy and social welfare policy.

Keywords: migration, care work, skill, Southeast Asia, Japan, Economic Partnership Agreement

1. Introduction

The dramatic demographic change caused by a low fertility rate and a rise in life expectancy has led policy makers and business sectors to rethink the future population prospects of Japan. The depopulation of productive age groups and an increasing burden on this age group to sustain the elderly population has become a social issue as well as a political one. Although James Hollifield (1992: 15) pointed out that Japan is the only industrial democracy that has not depended on foreign labor to achieve economic development, in the context of the changing demography, Japan accepting highly skilled migrants has been discussed as one option to cope

with the shortage of skilled laborers.[1] IT professionals, engineers, researchers and managers are in high demand, and both the state and businesses are trying to recruit international students who are already in Japan and who have become accustomed to the culture and language.[2]

Chris Manning and Alexandra Sidorenko (2006) point out that regulation of highly skilled sectors varies across occupations depending on the supply and demand in the labor market, the quality of the professionals, and the nature of the services they offer. For example, recruitment of IT professionals is initiated by business sectors and largely unregulated, as there are no educational requirements or specific certificates necessary for immigration. On the other hand, health workers are highly regulated by governments as health service is directly linked to the well-being of the nation. In addition, professional health-related organizations are much more likely to be able to sway policy regarding health professionals than professional IT organizations would be in an analogous case.

Among various categories of migrants, this paper highlights the migration of care workers to Japan. Interestingly, although in line with Japanese immigration policy, the recent migration of nurses and care workers[3] did not come about as the result of a "strategy" on the part of Japan to supplement the shortage of the domestic health and care workforce, but rather unexpectedly and arbitrarily as part of the bilateral agreements to promote free trade. The Economic Partnership Agreement (EPA) between Japan and the Philippines (JPEPA) was signed in 2006 and came into effect in October 2008. The EPA between Japan and Indonesia (JIEPA) was signed in 2007 and came into effect in July 2008. Both EPA included provisions for the movement of natural persons, which introduced migrants from Southeast Asia to Japanese hospitals and long-term care facilities for the first time in larger numbers.[4]

Based on these agreements, more than 1,300 nurses and care workers have been employed in Japanese hospitals and long-term care facilities since 2008. This paper will elaborate on the policy factors that enable or hinder the movement of nurses and care workers to Japan under the EPA, especially focusing on the skill of care workers three years after its implementation. Although the EPA include provisions specifically about nurses and care workers, the two occupations are constructed differently from one another in terms of labor market, professionalization, and educational requirements. While "nurse" is a universally acknowledged occupation that is recognized as highly skilled and that boasts well-organized professional

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1 In spring 2012, a "point system" will be introduced based on educational background, work experience and income to provide incentives to highly skilled migrants (*Asahi Shimbun* 2011/12/28).

2 In 2008, the Ministry of Education launched the "300,000 International Students Plan" (*Ryūgakusei 30man nin Keikaku*) as part of Japan's global strategy, whose target year is 2020 (MEXT 2008).

3 In this paper, I use the term "care worker" for those who are engaged in long-term care and as an equivalent English translation of the Japanese term *kaigoshi*.

4 Prior to the entry of migrants under the EPA, a small number of international students, foreign brides and nurses were working in hospitals and care facilities.

associations, "care worker" is a new occupation in response to the needs of aging societies in developed countries. This paper will focus on care workers in particular and discuss the dilemma that surrounds the skills required to undertake long-term care work. The data used for this paper are based on continuous fieldwork and surveys of both migrants and care facilities conducted 2008–present in Japan, Indonesia and the Philippines.

2. Framework of Migration of Nurses and Care Workers under the Economic Partnership Agreement

2.1 Literature on Migration of Health and Care Workers

Literature on the global migration of health and care workers has shed light on how migrants are providing much-needed care services that the state has fallen short of providing. There are two types of streams in the literature, one focusing on highly skilled professionals and the other focusing on unskilled migrants. First, the migration of health workers, including doctors and nurses, has attracted considerable attention and raised issues of ethical recruitment of and lack of opportunities for health professionals in developing countries. In Organisation for Economic Co-operation and Development (OECD) member countries, on average, eleven percent of employed nurses and 18 percent of employed doctors are foreign-born (OECD 2007: 162). They have now become an integral part of the national health-care system in the developed countries (Connell 2010). Second, reflecting the fact that the largest segment of work for women migrants is domestic work, there is a substantial body of literature on domestic workers (Anderson 2000; Constable 2007; Ehrenreich and Hochschild 2002; Parrenas 2003). In many parts of the world, cases of abuse and imprisonment of migrant domestic workers—referred to by some as "neoslavery"—working under unregulated conditions in private households have been reported (Ong 2006: 196). Scholars on gender (studies) have been discussing the relationship between global restructuring and an increase in female migration. They have established important concepts such as the "international division of reproductive labor" (Parrenas 2000), the "global care chain" (Hochschild 2000), and "global survival circuits" (Sassen 2004). These works have largely criticized the theories on migration that treat male and female movement within the same parameters for being gender-blind, and have revealed the global stratification process based on ethnicity, class and gender. This research has laid bare the unequal process of globalization where migrant women are increasingly mobilized into reproductive work in affluent countries, leaving their own care responsibilities behind.

The author argues that the literature on migration of health and care workers is polarized between highly skilled professionals, such as doctors and nurses, and unskilled domestic workers in private households who also provide care to the

children and the elderly. However, the occupational structure within the health and care institutions is more complex, and due to the rapid increase in the elderly population and a decreasing capacity of families to provide care, the need for long-term care workers will increase in the foreseeable future.

Having grown out of either the medical field or unpaid work within the family, caregiving as an occupation has been constructed differently in each country, reflecting the differing sociocultural and economic situations. This paper addresses the issue of migrant care workers in Japan, to which not much attention has been paid in the literature on migration and care, and discusses the contestation that arises from the nature of this work. Long-term care work is provided in an effort to sustain the daily lives of the elderly who are not able to live an independent life. In Japan, long-term care work consists of three basic forms of assistance in the activities of daily living: (1) eating, (2) bathing, (3) visiting the restroom and changing diapers. This does not include providing medical treatment.[5]

2.2 Background of the EPA

The number of bilateral EPA has increased especially after the World Trade Organization's Doha Development Round stagnated due to the conflict of interest in the multilateral negotiations. Japan's first EPA was established with Singapore in 1999 in the hope that it would strengthen the economic ties between Japan and ASEAN. The EPA negotiations between Japan and the Philippines started in 2003. During the negotiations, the Philippine government proposed accepting (1) nurses, (2) care workers, (3) nannies, and (4) domestic helpers (Asato 2007: 33); in line with the Japanese immigration policy of accepting the highly skilled but not the unskilled, the migration of nurses and care workers is allowed for by the agreement. In order to support its economic ties with countries in Southeast Asia, the Japanese government agreed, for political reasons, to accept migration to a certain degree. Thus, the migration of care workers is the outcome of a supply-driven proposal of sending countries rather than a demand-driven immigration policy of the Japanese labor market. The fact that Japan has a national certification system for care workers provided the legitimacy for accepting migrant care workers alongside with nurses. In addition, the demographic change and the Japanese public's anxiety over a care deficit have created an environment that welcomes migrants in the field of nursing and care.

The JIEPA followed the framework of the JPEPA and incorporated the acceptance of nurses and care workers. In October 2011, a further EPA with Vietnam was signed, and it also includes a provision regarding the migration of nurses and care

[5] Starting in April 2012, certain medical treatments are to be undertaken by care workers who have received adequate additional training.

workers. The number of nurses and care workers from Southeast Asian countries in Japan is depicted in Tables 1 and 2.

Table 1: Number of Indonesian and Filipino Nurses Who Arrived between 2008 and 2011

Year of arrival	Indonesian nurses, no. of entries	Indonesian nurses, no. of returnees	Indonesian nurses who passed the exam	Filipino nurses, no. of entries	Filipino nurses, no. of returnees	Filipino nurses who passed the exam
2008	104	77	15	0	0	0
2009	173	18	2	93	30	2
2010	39	3	0	46	4	0
2011	47	0	0	70	1	0
Total	363	98	17	209	35	0

Source: JICWELS (2012) and MHLW (2010a, 2011a)

Table 2: Number of Indonesian and Filipino Care Workers Who Arrived between 2008 and 2011

Year of arrival	Indonesian care workers, no. of entries	Indonesian care workers, no. of returnees	Filipino care workers, no. of entries	Filipino care workers, no. of returnees
2008	104	9	0	0
2009	189	15	190	32
2010	77	3	72	7
2011	58	0	61	1
Total	428	27	323	40

Source: JICWELS (2012)

The migration of care workers under EPA is shaped by three factors. First, it is strictly regulated by the state as the state institutions in both sending and receiving countries are heavily involved in recruitment, matching, training and deployment. Second, the entry of migrant care workers was accepted not merely as a negotiation between Japan and Southeast Asian countries but also as a compromise between different Japanese ministries, which pursue diverse goals. The Ministry of Foreign Affairs (MOFA) and the Ministry of Economy, Trade and Industry (METI) are in favor of the agreements, while the Ministry of Health, Labour and Welfare (MHLW) has fiercely defended the domestic labor market. MHLW claims that the acceptance of migrant nurses and care workers is an "exceptional" case that emerged under the EPA and that it is not due to shortages in the domestic care workforce (MHLW 2011b). The MHLW clearly prioritizes the employment of Japanese workers while maintaining a fine balance by also supporting the migrant nurses and care workers in order not to damage diplomatic relationships. Third, the migration of care workers

under EPA has been shaped by pressure from professional organizations, which have had a distinct influence on the migration project. During negotiations, fearing that the influx of foreign nurses may impair working conditions and undermine nurses' professionalism, the Japanese Nursing Association made a counterproposal that shaped the framework of migration of care workers under the EPA in the following ways: (1) foreign nurses are required to pass the Japanese national licensure exam in order to work as nurses in Japan; (2) foreign nurses need to have good language proficiency in order to provide safe nursing care; (3) foreign nurses should be employed under the same working conditions as Japanese nurses; and (4) there is to be no mutual recognition of nursing licenses (JNA 2006). Based on these recommendations, the EPA made it a condition that foreign nurses and care workers need to pass the national exam within a limited period of time; if they fail, they cannot stay in Japan any longer. The period of residency has been defined as three years for nurses and four years for care workers. This is because the care workers need three years of working experience in order to qualify to take the exam. Also, unlike the migrants in other categories,[6] they are entitled to the same salary, working conditions, social benefits, and protection under the same labor laws as their Japanese colleagues.

Until 2010, Indonesian and Filipino nurses and care workers received six months of free Japanese language training. From 2011 onward, due to the demand of hospitals and care facilities for the nurses and care workers to improve their Japanese language skills, the period of language training was extended. After intensive language training, once they are placed in hospitals and nursing homes, the institutions are expected to continue providing these workers with Japanese language education and to support them in preparing for the examination. Theoretically, free education and the condition of having to pass the exam seemed as if it might open a pathway for migrants to integrate into the care labor market in the same way as their Japanese counterparts, but in practice it did not turn out that way, as I will discuss later on.

Even though the official position of the government is that the acceptance of the migrants is not based on a need to compensate for the shortage of domestic care workers, the same ministry also states that Japan will need 400,000 to 600,000 care workers in the next decade (MHLW 2009). Considering the shrinking size of the productive population and the growing number of elderly, it is not possible to fulfill this need entirely with the domestic workforce. We have yet to see effective measures be taken aside from the provision of vocational training on caregiving to unemployed persons. This implies that care work is poorly remunerated and in general shunned by local populations.

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[6] This refers to *nikkei* (ethnic Japanese repatriates) and trainees who work under more vulnerable conditions.

Both the rising costs of care and the deficit of care workers became big issues in the media and led to national anxiety about the provision of care. Care work is labeled "3D" (dirty, dangerous and difficult) work with low remuneration, leading to the media having repeatedly addressed this so-called "crisis of care" (*Asahi Shimbun* 2008/08/01; *Mainichi Shimbun* 2009/12/23; *Nihon Keizai Shimbun* 2011/10/05). Reflecting Japanese citizens' fears and anxieties over their twilight years, the entry of migrant care workers into the space of caregiving has ironically attracted great attention from the media, making the migrants and their workplaces highly visible. Numerous reports and documentary programs have been produced featuring stories about how the migrants are struggling to learn Japanese and how they adjust to their workplaces. The presence of young migrants coming to Japan to work in order to support their families resonates with the "good old days" of the elderly, who nostalgically remember the time when Japan was still poor and they had to struggle to make ends meet. The narratives of the hard-working migrants struggling for upward mobility perfectly fit within the discourse of post-war Japan, when the country achieved rapid economic development that is unthinkable nowadays. Many care facilities that accepted migrant care workers were featured in newspapers and TV programs that portrayed the human aspect of cross-cultural exchange taking place within the field of care.[7] The entry of migrants encouraged care facilities to provide quality care and inspired the staff to learn about different cultures, thus revitalizing the workplace (Ogawa *et al*. 2010).

3. Profile of Migrant Care Workers

A Kyushu University research team[8] conducted a survey on the second group of Indonesian care workers, who arrived in 2009, and the first group of Filipino care workers, who arrived in the same year. Table 3 shows the profiles of the two groups.

While the two groups were recruited under the same mechanism, Table 3 shows that they differ in certain aspects. First, in terms of age, the Filipino care workers are on average seven years older, often having left their families in their home countries, in contrast to the Indonesians, who are generally young and unmarried. The responsibility to economically support their families has been felt much more strongly by the Filipinos than by the Indonesians, who are more career-oriented. This is not to suggest that the Indonesians do not have economic motivations in working in Japan; economic considerations are one among many underlying factors of all forms of migration. Further research is needed in order to be able to compare

[7] For example, NHK Holiday Nippon "Boku ga soba ni imasu kara: Indoneshiajin kaigo funtōki" (I will be beside you: The Struggle of Indonesian Care Workers) (2009/09/22) and NHK Fukushi Network "Teichaku suruka gaikokujin kaigoshi" (Will the foreign care workers stay?) (2010/04/08).

[8] The research was funded by Kyushu University Interdisciplinary Programs in Education and Projects in Research Development (representative: Shun Ohno). The research team members are Shun Ohno, Yuko Hirano, Yoshichika Kawaguchi, Kiyoshi Adachi, Takeo Ogawa and Reiko Ogawa.

the social status of nurses, job markets, and discourse on migration of nurses and care workers in the two countries.

Table 3: Profile of Migrant Care Workers under the EPA

	Indonesia n=182	**Philippines n=272**
Average age	23.7 (SD2.57)	30.5 (SD4.17)
Sex	Female 77%	Female 88.8%
Place of residence	Jakarta 6.6% West Java 53.2% Central Java 12.1% East Java 8.2%	Metro Manila (MM) 23.8% Luzon excluding MM 53.4% Visayas 7% Mindanao 20%
Religion	Muslim 91% Protestant 5.5%	Catholic 84% Protestant 5%
Marital status	Married 8.3%	Married 33.1%
Children	6.5%	44.8%
Education	Nursing 60.2% Other 39.8%	Nursing 50% Other 46.7% Nursing plus other 3.3%
Previous stay in Japan	2.7%	12.9%
Working experience as a nurse	25.5%	47.2%
Working experience as a caregiver/care worker	14.6%	35.3%
Overseas working experience	as a nurse 1.3% as a caregiver 0%	as a nurse 14.9% as a caregiver 8.4%
Family members working overseas as nurse or caregiver / care worker	4.4%	23.2%
Economic conditions	very difficult to survive 1.7% difficult to survive 41.7% not so difficult to survive 56.6%	very difficult to survive 1.9% difficult to survive 68.5% not so difficult to survive 29.6%
Overseas working experience	as a nurse 1.3% as a caregiver 0%	as a nurse 14.9% as a caregiver 8.4%

Source: Data were collected from the second group of Indonesian care workers (2009) in Bandung, Indonesia, in July 2009 and from the first group of Filipino care workers (2009) in Manila, Philippines, in May 2009 in collaboration with Human Resocia and the Philippine Overseas Employment Administration. The response rates were 99.2 percent and 95.4 percent, respectively (Adachi *et al*. 2010).

Second, related to the age difference, Filipinos have more experience in working as nurses both locally and overseas. They also have family members working overseas as nurses or care workers. The migration of nurses from the Philippines has a long history, starting during the American colonial period and slowly establishing itself

globally (Choy 2003). The Filipino nurses are able to work in English and are therefore more integrated into the global care market, which affects their understanding of "being in Japan." In fact, several Filipinos have already left Japan and migrated to Canada as live-in caregivers, a country without language barriers for Filipinos, where they can obtain citizenship after two years. Although the government, especially the MHLW, is concerned about the "protection" of the domestic labor market, this fact shows us that migrants are more flexible in foreseeing the global care labor market by utilizing their agency and seeking out better options for their future. The EPA not only lump together the two different occupations of nurse and care worker but introduce the same system to two countries with significant differences in their profiles.

4. Three Years after the Implementation

4.1 Assessment of the Migrant Care Workers

In 2010, the Kyushu University research team conducted quantitative research at care facilities one year after the first group of Indonesian care workers was placed.[9] Responding to a question on changes that occurred after accepting the Indonesian care workers, 89.5 percent replied "applicable" or "somewhat applicable" to the statement "the workplace became revitalized." Also, 52.7 percent replied "applicable" or "somewhat applicable" to "the elderly became lively" (Ogawa 2012: 580). In the author's interviews at more than twenty care facilities, all agreed that the migrant care workers are very popular, especially among the elderly, as they are kind and gentle.

In the assessment of Indonesian care workers, 100 percent of the care facilities replied "applicable" or "somewhat applicable" to "they have respect towards the elderly" and 94.7 percent responded "applicable" or "somewhat applicable" to "they are good at building relationships with the elderly." A number of directors of care facilities pointed out that in spite of the language barrier, the migrant care workers are able to relate to the elderly in a very natural manner. This statement is made as a comparison to Japan's younger generations, who no longer live with their grandparents, lack experience in developing relationships with the elderly, and need to be taught how to provide care to the elderly starting with the basics. These findings indicate that the migrant workers are having a positive impact on the quality of caregiving.

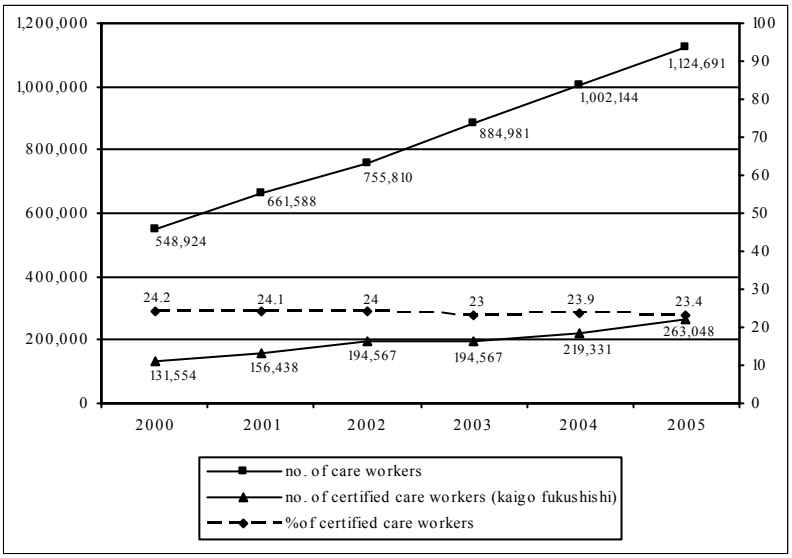
[9] In January 2010 the questionnaire was distributed to the 53 care facilities that accepted the first group of 104 Indonesian care workers, one year after their acceptance. The response rate was 35 percent. For further details see Ogawa (2012).

4.2 Between "Skilled" and "Unskilled"

Despite a warm welcome at the care facilities, the condition of having to pass the national exam is a very high barrier for the migrants if they wish to continue working in Japan. The passing ratio for the Japanese nursing exam in 2010 was 91.8 percent for Japanese students as most of them come straight from school. The passing ratio for the Japanese certified care worker exam in 2010 was 50.2 percent, since many take the exam while working.

The national certificate for care workers was established in 1987 to professionalize care work within the rapidly aging society. In order to become a certified care worker one has to be either a graduate of a two-year course in higher education or pass the national exam after three years of work experience as a care worker. There is another certificate called "home helper," which is accredited by the local government. As a prerequisite for obtaining the "home helper" status, one has to undertake 130 to 230 hours of courses, depending on the degree level. While the certified care worker certificate is a national certificate requiring the passing of an exam, the home helper is a publicly administered certificate that one can obtain by attending accredited courses.

Figure 1: Number of Care Workers in Facilities and Home Care



Source: MHLW (2007)

Figure 1 indicates the number of care workers that have been hired since Long Term Care Insurance (LTCI, *kaigo hoken*) was introduced in 2000. Ever since, the number of care workers has grown rapidly, by approximately 100,000 per year, but the ratio of the certified care workers has remained between 23 and 24 percent. This reflects the high turnover rate among the certified care workers; the certificate holders do not necessarily remain in the care job market. Also, it indicates that the work of caregiving is undertaken by people from various backgrounds and not always by those who possess the national certificate. The care facilities are run not only by professionals who have a bachelor's degree in "social welfare" or "caregiving" or who possess the care worker certificate but also by people from diverse backgrounds in terms of age, gender, education, previous occupations and certification. One director of a care facility in Tokyo says (2012/02/16):

> It is better [for a job applicant] to have the license of a home helper or certified care worker, but it is not a must when we recruit our staff. Often, a middle-aged woman who has been taking care of her father at home becomes a better care worker than a fresh graduate with a certificate.

This statement demonstrates the view that care work is an extension of family care, the latter of which has yet to be established as a professional occupation. If the national certificate is not necessarily required for Japanese staff, what does it mean to require a certificate from the migrants? Although highly skilled workers are usually defined as "those with university degrees or extensive experience in a given field" (Iredale 2000), the distinction between skilled and unskilled is politically constructed within the national immigration policy. The requirements to work as a certified care worker within the EPA framework are contested terrain because care work in fact is regarded as 3D work in Japan. However, since it has been lumped together with nursing, it has been upgraded to skilled work. This contradiction can be seen in the Immigration Control and Refugee Recognition Act (*Shutsunyūkoku kanri oyobi nanmin nintei-hō*), which lists 16 categories for specialized and technical work, including diplomatic missions, media, arts, religious activities, legal and accounting services, medical services, research and education. While medical doctors, dentists and nurses are entitled to medical visas,[10] certified care workers are not entitled to a residential status based on these categories. The reason for this lack of residential status is not clear, but according to interviews with the MHLW (2011/08/25) and a politician from the Liberal Democratic Party who aims to liberalize the care labor market for migrants (2011/07/11), it depends on whether caregiving can be considered "skilled" work or not. Even after the establishment of the certified care worker system, the expertise of the care workers remains contested. Unlike registered nurses, who are required to have a certificate for the conduct of medical treatment, obtaining the status of a certified care worker does not

[10] In 2010, there were 265 medical visa holders, most from China and Korea, employed as health workers (MOJ 2011).

allow one to have any autonomy in one's work. In other words, whether or not one has a certificate, the job that one does is exactly the same. However, according to the aforementioned interviewee, one has to have the certificate to move up into managerial positions, in which case the salary increases between 5,000 to 20,000 yen per month.[11] Whether certified care workers are considered "skilled" has not gained consensus, and how exactly to define the "skill" or the "expertise" of a care worker is still much debated (Soeda 2008).

In many countries, long-term care has been undertaken by a live-in or live-out migrant domestic helper who is expected to take on domestic chores aside from elderly care (Constable 2007; Rivas 2002; Wang 2010). Although Japan has established a certified care worker system, to what extent care work can and should be professionalized remains unanswered. In the EPA provisions, nurses and care workers are lumped together within the same framework, but these two occupations are constructed differently with distinct job descriptions, educational systems, stakeholders, labor markets, and degrees of autonomy. Instead of defining the skills and expertise of care work and solving the internal confusion before accepting migrants, the sudden enactment of the EPA has mandated that the care workers pass the national exam.

In the two sending countries, care work as an occupation is underdeveloped and constructed differently. The Philippines introduced a certified care-giver system in the 1990s that is accredited by the government. Yet, this system was introduced with the purpose of sending migrants to Canada and elsewhere to work as live-in caregivers, not as a way to meet the demand in its own domestic labor market. This course requires six to seven months of training in caregiving to children, the disabled, and the elderly in private homes, but not all graduates are able to find jobs overseas (Ogawa 2009).

In Indonesia, responding to the EPA, the government established a certified care worker course in 2009, but after providing training to the candidates, many of them were unable to find jobs in Japan as they could not be matched with Japanese institutions. This was because the Japanese care facilities preferred those candidates with a nursing background over graduates of short-term certified care worker courses. This brought great embarrassment to the Indonesian government, so after one year it stopped running the course.[12] As a result, an increasing number of applicants from Indonesia come from a nursing background.

In Table 3, despite the differences in profiles, what the migrant care workers have in common is that more than half are graduates of nursing schools/universities. The qualifications necessary to work as a care worker under EPA are as follows:

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[11] This amounts to roughly 50 to 200 euros per month.

[12] Interview with an official at the National Board for Placement and Protection of Indonesian Overseas Workers (BNP2TKI) in July 2010.

For Indonesia:

Candidates must (1) be graduates of a three-year vocational school in nursing or have a bachelor of science degree in nursing, or (2) be graduates of any vocational school or university (more than three years) and possess the certificate for care workers accredited by the Indonesian government.

For the Philippines:

Candidates must (1) hold a bachelor of science degree in nursing, or (2) be graduates of any four-year university and possess the certificate for care workers accredited by the Philippine government.[13]

Therefore, it is natural that many migrants have a nursing background. However, concerns have been raised about the "brain drain" or "brain waste:" health professionals are leaving a country that has not met its own primary health-care needs (Shah 2010).

Among the applicants in Table 3, 51.8 percent of the Filipinos and 32.4 percent of the Indonesians replied that they were jobless at the time they applied to the JPEPA and the JIEPA. Even some of those who have obtained a license[14] have been working as "volunteer nurses" or "honoraria nurses;" both work in hospitals in order to gain clinical experience but do not get paid the full salary. The health workers are unequally distributed and tend to become concentrated in urban centers, where the working conditions and salaries are better. In rural areas, the numbers of both health facilities and workers are limited, resulting in poor health provision for the local populations.

The Philippine Nursing Association opposes the sending of their nurses to work in Japan under the JPEPA (Samaco-Paquiz n/a), and the Philippine government has also criticized the high requirements for Filipino care worker candidates to work in Japan (Ohno and Ogawa 2010: 145). The Indonesian Nursing Association is also against their nurses working as care workers in Japan.[15] However, no opinion has been voiced by the Japanese medical and welfare organizations, which are primarily concerned about the domestic labor market. Since the skills involved in care work are not clearly defined in Japan, the expectations for the migrants are consequently very vague. There is hardly any discussion among the care institutions regarding what kind of background the care facilities expect from the migrants. This epitomizes the paradox that although we live in an age of increased global capitalism, labor markets are still largely constructed nationally and skilled workers tend to get trapped because their credentials are confined to national boundaries.

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13 The difference in the requirements is due to the difference in schooling systems in Indonesia and the Philippines.

14 The Philippines has long had a registered nurse system, but Indonesia has just recently introduced one. Therefore the term "license" has different meanings in these two countries.

15 Interview with the former president of the Indonesian Nursing Association in July 2010.

Migrant care workers with nursing backgrounds are appreciated because they have a basic knowledge of diseases and medicine and have studied anatomy, which is useful in their daily care tasks. There is no doubt that this background has contributed to the positive branding of the migrants as "professionals." However, one question still lingers: Is this "brain waste," or are the migrants able to use their migratory experience to develop certain career paths for themselves later on? The migration of health workers reflects the uneven process of globalization; in this context, the ethical issues of recruitment need to be examined more closely. Although an educational project on nursing in Indonesia has been conceived under the JICA (Japan International Cooperation Agency), an integrative approach combining migration and development in the field of care has yet to be envisioned.

This issue of career paths is far more critical for nurses, whose occupation is more professionalized than that of care workers. Unlike care workers, for whom obtaining a certificate does not change their job description at all, nurses working in Japan have to obtain the status of registered nurse in order to perform medical treatment. Migrant nurses can work only as nurse assistants until they pass the national exam in Japanese. For those who have not passed the exam, the daily work in the hospital is to feed and bathe the patients, assist them in going to the restroom, make tea, and clean rooms—very similar tasks to those performed by care workers. The fact that migrant nurses are not allowed to perform medical treatment—although this was explained to them during orientation in their home countries—is a big source of discontent, as their skills tend to deteriorate during their stay in Japan (Setyowati 2010). Several nurses that I know left Japan to go back to the nursing track in their home country or to work elsewhere.

One Indonesian nurse who passed the national exam on nursing but decided to return to Indonesia for family reasons said that she was able to find a job in a private hospital in Jakarta, but this was not because of her experience working in Japan. Her three years in Japan appear in her CV as "nurse assistant" and do not count towards her career in nursing. Before going to Japan she had worked for eight years in Jakarta as an intensive care nurse, and it was this experience that enabled her to find a job. Moreover, she did not even tell her new employer that she had passed the Japanese national exam on nursing because at the time of her interview she did not have the certificate and also wondered whether the employer would be able to appreciate the value of it.[16] Unlike a university degree, Japan's registered nurse certification may not prove useful beyond national boundaries, since there is no mutual recognition of nursing licenses. If the registered nurse license is not universally recognized, what is the use of becoming a certified care worker in Japan and obtaining a license that cannot be used anywhere else in the world? What is the value of investing so much time and money when the migrants might not stay in Japan their whole working lives? The underlying assumption of this migratory

[16] Interviewed in July 2011.

scheme for nurses and care workers is based on a naive understanding that the migrants will stay in Japan once they pass the national exam; the large number of returnees indicates that migrants have their own distinct priorities and plans for their lives.

The first group of Indonesian care workers took the first exam in January 2011. Migrants who wish to stay longer in Japan struggle hard to prepare for the exam, but the delicate balance between "work" and "study" is another source of contestation, as we will see in the next section.

4.3 Between "Work" and "Study"

The migrant care workers are well adjusted to the care facilities, and after two to three months they are working as members of the team. The language barrier remains a constraint for them to fully participate in staff meetings and manage the care documents but the migrants are trying hard to learn their tasks and study Japanese. At the more supportive care facilities, they are trained not only in personal care but also in the management of the facilities themselves and are expected to become managers someday. In these facilities, the migrants are highly motivated to study, pass the exam, and work in the care facilities as long as possible.

The care facilities, which are all expected to provide support, are struggling to find ways to help the migrants pass the national exam. The type of support offered depends on the policy and resources of each facility, but in general it includes supervision by the Japanese staff, hiring a Japanese language teacher and/or expert in caregiving to help the migrants prepare for the exam, sending the applicants to school to learn Japanese and/or caregiving, or sending them to training courses or mock exams provided by the government. On top of these educational costs, the care facilities pay approximately 600,000 yen for the initial cost for placing migrants in care facilities and Japanese language training, paying a salary equal to that of their Japanese co-workers,[17] and providing benefits such as housing or food allowances although the migrant care workers are not counted as staff under government regulations. In our research sample, 100 percent of the care facilities responded "applicable" or "somewhat applicable" to "the work load of the staff in charge of education has increased;" also, regarding the financial burden, 89.5 percent of the facilities responded "applicable" or "somewhat applicable" to "the financial burden has increased" (Ogawa 2012: 582). Even a director of a care facility in Tokyo who highly appreciates the Indonesian and Filipino care workers says (2012/01/19):

> We do not mind investing in education if we know that once they [the migrants] pass the exam they will stay with us. But what's the point of investing in something from which you may not profit? I want the government to compensate our expenditure!

[17] For the first group of Indonesian care worker candidates, the highest monthly salary is 197,550 yen (approx. 1975.50 euros) and the lowest is 120,000 yen (1200.00 euros) (Satomi 2010).

The care facilities that run educational institutions or large care facilities with multiple incomes are in an advantageous position regarding resources, but for small facilities it is difficult to retrieve the costs of supporting the migrant care workers. The results of the EPA have been contradictory in that while the migrants are well accepted and appreciated by the elderly, the care facilities are overstretched in providing support. Three years after its implementation, the migratory scheme, which mandates that the institutions support the migrants in passing the exam, is increasingly becoming flawed because how this mandate is understood and undertaken is up to the "good will" of the institutions. Considering the low passing rate for migrant nurses (Table 2), care facilities that are not interested in investing in migrants whose chances of passing might be very low turned out to be not providing any support.

According to research conducted by the MHLW (2010b),[18] there is a big disparity in the ways in which the facilities provide support. Responding to the question "How many hours a week do they [the migrants] study Japanese?", 2.7 percent of the care facilities replied that they "do not provide support at all;" 47.9 percent said "between one and five hours;" 39.7 percent said "between six and ten hours;" and 12.3 percent said "more than eleven hours." The big difference in providing or not providing support to the study of Japanese is one of the major sources of discontent among the migrants. Some are working eight hours a day, five days a week and are left without any support. Others are working six hours a day, allocating a further two hours every day to their studies in addition to Japanese language classes one afternoon each week. Some are given the chance to attend the intensive course on caregiving while others were never admitted to participate because the care facility refuses to shoulder the extra costs of transportation and accommodation. Some were given support until recently when several Japanese staff members resigned at the same time and the shortage of labor made it impossible for the migrant workers to concentrate on their studies until new staff was recruited.

Although the EPA are a government project, the state has the power neither to impose the training component on the care facilities nor to establish a standardized contract that sets the minimum hours of training. The unfortunate migrants who were placed in facilities without "good will" are left in the lurch and decide not to waste their time in Japan. There is a growing discrepancy between the official mandate of the scheme to require the migrants to pass the national exam and the reality of the government not being able to control the flawed facilities. Also, on the side of the migrants, sometimes they are not well prepared to study so hard and feel pressured and exhausted by working and studying at the same time. Some have left

[18] The research was conducted in 2010 targeting 53 care facilities that accepted the first group of Indonesian care workers. Responses were received from 39 care facilities and from a total of 528 persons including directors, staff in charge of training, general staff, elderly patients and their families and Indonesian care workers.

Japan considering the hard work that they have to go through in learning Japanese, especially medical terminology, and their low chances of passing the exam.

Under these circumstances, the only successful case is when "motivated migrants are placed in the motivated facilities" (Type 1), where migrants aspire to upward career development and wish to stay in Japan. But theoretically and empirically there are other cases such as "motivated migrants in flawed facilities" (Type 2), "less motivated migrants in motivated facilities" (Type 3), and "less motivated migrants in flawed facilities" (Type 4). While the unfortunate combination exemplified by Types 2 and 3 can result in desperate institutions and in migrants returning to their home countries, if the passing ratio of the national exam continues to be very low, it can be anticipated that neither migrants nor facilities will raise their expectations of passing and that enthusiasm will diminish, resulting in a proliferation of Type 4. If that occurs, the EPA will become another type of circular labor migration scheme.

In research undertaken by Kyushu University on care facilities that accepted the first group of Indonesian migrants, 84.2 percent replied "agree" or "somewhat agree" to the opinion that "migrants do not need to obtain the certified care worker license in four years." Also, 79.0 percent checked "agree" or "somewhat agree" in response to "the Japanese government should open the door for the employment of foreign care workers," and 84.2 percent responded with "agree" or "somewhat agree" to the opinion that "for those who obtained the certified care worker license, the government should grant them a permanent residential status" (Ogawa *et al.* 2010). In the interviews, many care facilities pointed out that care workers need not possess the national certificate to be hired, and a discussion on how to lower the hurdle is taking place.[19]

As indicated in the studies on migration and care, long-term care workers are situated somewhere between highly skilled professional health workers, such as doctors and nurses, and unskilled domestic workers. Given this occupational hierarchy and the lack of political leadership, the difficulty for Japan lies in how the government should situate care work within the spectrum between skilled and unskilled. If the government continues to lump care work together with nursing and insists that the migrant pass the national exam without providing support to the care facilities, then the number of institutions willing to accept migrants and provide proper support for them will continue to decrease (Table 2). Even among those facilities that have accepted migrants, the circular migration of Type 4 will persist, undermining the original intention of the EPA. In the meantime, the care deficit will continue to leave thousands of elderly uncared for. However, if care work were considered unskilled work with very minimal requirements, Japan would need to change its immigration policy to accept these "unskilled" migrants. This option may

[19] Meeting of non-governmental organizations in November 2011.

attract a larger number of migrants, but the working conditions may further deteriorate, and eventually care work will become a job for migrant women, leading to further polarization in the already segmented labor market along ethnic and gender lines.

5. Conclusion

Although the care work deficit is becoming a social issue, the migration of nurses and care workers was not demand-driven but rather supply-driven, as it was based on the proposals of sending countries. The state and professional organizations have shaped its framework, making it a condition for the migrants to pass the national exam within a certain period of time. However, in the case of care workers, the meaning of the certificate has become contested because the "skill" involved in caregiving is not well defined, and the certificate is not a prerequisite to work as a care worker. While the migrants are expected to pass the exam, the flawed care facilities may not provide the training the migrants need to prepare for the exam. Whether care work should be categorized as skilled or unskilled remains contested and will define Japan's future immigration policy, labor policy and social welfare policy.

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