Healthcare: Japan’s Case

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* This is a DRAFT paper.

Abstract
Japan’s healthcare sector has two major barriers: qualifications/licenses that are valid in Japan, and fluency in Japanese. Thus, the number of immigrant workers remains very low, although Japan is faced with severe staff shortage. Even under the special bilateral arrangement that allows nurses from Indonesia and Philippines to practice temporally and to be qualified in Japan, there are very few foreign nurses who passed the national examination: it is difficult for them to read technical terms written in Chinese Characters. In care subsector, in which wage is low, the number of employed foreign-born residents is rapidly increased. Local governments begin to help foreign-born residents to complete care courses. In terms of the supply of workforce, language support is necessary to increase the number of foreign-born workers. In terms of competitiveness of inbound and outbound businesses, Japanese language matters little in mobilizing immigrant workers, but it is necessary to introduce systematic efforts to bring up staffs.

Key Words: aging population, staff shortage, inbound and outbound businesses, Economic Partnership Agreement (EPA), language support

1 This is the revised version of the paper that is presented at the Japan-US Migration and Competitiveness Conference (March 22, 2012). Author thanks the participants of the Conference for their comments and suggestions, especially Charles Harns, Rick Mines, Byung-Kwang Yoo, and Keiko Yamanaka.
Introduction
Today, developed economies are equally faced with low competitiveness, high unemployment rate and aging population. As far as healthcare sector is concerned, aging population requires more financial and human resource than ever, but low birth rate reveals that younger generation cannot supply enough financial and human resource to afford seniors. Every developed economy, especially Japan that enters the era of aging population faster than other OECD countries, has to tackle with the shortage of healthcare workforce. This paper analyzes Japan’s healthcare sector in terms of migration and competitiveness, and outlines Japan’s status quo and problems to be solved.

The first section of this paper outlines Japan’s healthcare sector, by introducing the scale of healthcare sector in the national economy, the demographical trend, and the labor market data. The second section exhibits the positions of the ministries toward the status quo in the healthcare sector. The section highlights that there is two kinds of understanding the competitiveness: to meet the demands of workforce, and developing inbound and outbound market for healthcare-related industries. The third section touches on the migrant employment in Japan. It examines the statistical trends of foreign-born workers, introduces Japan’s attempts to invite oversea practitioners under bilateral agreements, and then examines the MHLW’s (Ministry of Health, Labour and Law) position for immigrant workers and the actual situations in care subsector. The fourth section touches on the alternative options and scenarios for Japan in terms of competitiveness and migrant workers, and the last section concludes this paper.

1. Outlines of Japan’s Healthcare Sector
In Japan, healthcare is not a large industrial sector in the national economy. The OECD Health Data 2011 reported that Japan’s total expenditure on health is 8.5% of gross domestic product (in 2008). Although the amount itself has been steadily increasing, it is relatively low, if compared with other OECD member countries such as the United States (16.0%), France (11.1%), Germany (10.7%) and the UK (9.8%).

People’s expenditure on health is also lower than other major OECD countries. In 2008, Japan’s total expenditure on health per capita (PPP: purchasing power parity) was 2,878 US dollar, and it was lower than the OECD average (3,101 US dollar). Pharmaceutical expenditure per capita (PPP) was 558.3 US dollar and it was also lower than the OECD average (939.5 US dollar). Such small amount of expenditure is thought
to be a consequence of the universal health insurance system (national insurance system that covers all of citizens).

When we examine the changing demographics in Japan, however, we can find another feature in this sector. Among the major OECD countries, Japan is faced with severe aging population (chart 1). Population over 65 has exceeded 20% of the total population, and the percentage is expected to reach 40% in 2060 (chart 1 and 2). In 2012, the number of people that are authorized/certificated by the government to receive long-term care has reached to 5 million (beyond 4% of the total population).

In response to such a demographic trend, the number of employed person in the healthcare sector has been increasing, while the numbers of employees are shrinking in other sectors (Chart 3). Of all the industrial sectors, healthcare sector and ICT sector are the growing labor markets. However, in the healthcare sector, the demand of workforce grows more rapidly than the supply: the number of un-fulfillment of job offers in this sector has also increased from 23.6 thousands in 2005 to 36.8 thousands in 2010, while the numbers of other sectors and total have been almost halved².

Staff shortage can be found in every subsector. For example, every prefecture is faced with the shortage of practicing physicians, if compared with the OECD average of 3.1 physicians per 1,000 inhabitants (Figure 1). As for nurses, the urban areas, especially prefectures in Kanto district (around Tokyo), are below the OECD average of 8.4 nurses per 1,000 inhabitants (Figure 2). The same situation can be found in the long-term care subsector. Facilities for long-term care need much workforce than ever, in response to the aging population. An investigation conducted by the Care Work Foundation exhibits that 24 percent of facilities use posting workers in order to hire nursing and caring staffs, especially home-visit caring staffs³. Another investigation by the same foundation exhibits that the ratio of leaving jobs of contractual employees reaches 25% while that of regular employees is 15 to 17% in care facilities, and shows that these facilities have difficulties in hiring alternative staffs⁴.

In general, shortage of workforce in domestic labor market will trigger inflow of immigrant workers. How does Japan deal with staff shortage, and whether does it invite immigrant workers? The next section introduces positions, interests and policies of ministries, in order to outline Japan’s understanding of competition and migration in the healthcare sector.

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³ Care Work Foundation (2008), p.46.
⁴ Care Work Foundation (2011), pp.90, 109, 111 and 112.
2. Different Positions, Interests and Policies among Ministries

Currently, the government and ministries take different policy approaches within their competences, and they do not succeed in collaborating closely for the healthcare sector.

The Cabinet Office published a new growth strategy in 2010\(^5\), and it emphasized that healthcare is one of the important sectors for economic growth. It emphasized that demands of citizens are not matched by supply, and also pointed out potential demands in abroad, especially in Asia. The strategy estimated the healthcare sector would bring us a new market that held 103 trillion yen and 280 thousands of jobs by 2020. To develop the new market, the strategy urged to promote research and development in medicine and medical/care technology, and to boost overseas sales of medicines and provision of medical examination/treatment services. The strategy also introduced an action program that contains regulatory changes in visa policies and deregulations of consultations by foreign physicians and nurses. These suggestions were carried into actions: medical translation courses for English, Russian and Chinese were established and some medical institutions are advertised in these languages; and regulation was improved for clinical trainings of foreign practitioners and patients\(^6\).

The Ministry of Economy, Trade and Industry (METI) also thinks healthcare as a growth and competitive industry. A committee in charge of healthcare industry starts to consider the future promotion of both inbound and outbound businesses: it promotes to accept oversea patients by bringing up medical translators so that medical institutions can secure the necessary numbers of cases for technical improvements; and it also aims at supporting to establish outreach medical institutions/facilities and exporting medical equipment and services, by promoting exchanging human resources\(^7\). Though there is currently no comprehensive project/program that is specifically prepared for healthcare industry, international technical cooperation and human exchanges are developed under a part of general schema such as the Overseas Human Resources and Industry Development Association (HIDA), the Association for Overseas Technical Scholarship (AOTS) and the Career Development Program for Foreign Students in Japan.

The Ministry of Foreign Affairs (MOFA) has come to concern free trade including human exchanges in the era of globalization. It considers it necessary to promote free

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movement of natural person in terms of trade liberalization, and promotes to accept oversea workers by concluding bilateral agreements (for example, see the Economic Partnership Agreements in the next section). The Immigration Bureau of Japan aims at inviting highly skilled immigrant workers to stimulate competitiveness especially in the field of research and development, and introduced a new point-based immigration policy. Healthcare workers who engage in research and development or clinical training may be covered under the policy. However, the policy does not open the gate for all of the immigrant healthcare workers who want to practice in Japan. It is the Ministry of Health, Labour and Welfare (MHLW) that regulates the labor market in the healthcare sector.

The MHLW regulates the licenses and qualifications, registration, activities of medical institutions and staffs. The MHLW is also in charge of human resource planning: it has historically planned the number of practitioners in the healthcare sector, by estimating the demand and supply of workforce. Under the Medical Care Act, the MHLW has its own calculation measure for deciding the desirable number of healthcare workers, and it does not figure in the immigrant workers. The MHLW emphasizes that the staff demand are matched by mobilizing local practitioners.

Japan has no bilateral international agreement on mutual and automatic recognition of professional qualifications and licenses in healthcare sector that allow immigrant practitioners freely practice in Japan. The MHLW does not allow immigrant workers to practice in Japan, unless they are qualified as professional practitioners by Japan’s national examination. Thus, immigrant workers, who want to practice in Japan, have to pass the national examinations held in Japan. If an immigrant worker wants to take the national examination, they have to undergo a review of eligibility requirements for the examination in advance. If he/she is judged to meet the requirements, then his/her language fluency is examined before he/she is formally judged as eligible to take examination. If applicants do not graduate from junior-high and high schools in Japan, they have to pass the Japanese Language Proficiency Test (Grade N1). Dozens of people are judged as eligible to take national examinations in every year: most of them

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8 Japan has bilateral agreements for interchanging physician’s licenses with France, Singapore, the United Kingdom and the United States. However, these agreements have many restrictions: such as the number of physicians that are allowed medical examinations and treatments, the places where they can practice, and the people whom they can practice medical examinations and treatments.

9 In contrast to some other countries, Japanese government does not hold the national examinations in abroad.

10 The assessment of language fluency expects applicants to exhibit enough language abilities to practice medical examinations and treatments.
are Chinese or Korean nationality. The MHLW requires immigrant practitioners to hold qualifications valid in Japan and to be fluent in Japanese, even if they have been already qualified and being practicing in their home countries. Such regulatory policy reveals that the MHLW does not see healthcare sector as competitive market, in contrast to the Cabinet Office and the METI. It sees healthcare as a kind of social security and it works for securing national healthcare system.

As we can see, there are two ways of understanding for competitiveness in this sector: one understanding is to supply enough workforces to match local demands; and the other is to enhance inbound and outbound business activities through technical cooperation and human exchanges. However, in contrast to the METI and MOFA, the MHLW, the regulator of healthcare practitioners, does not consider the healthcare as competitive market, and does not count on immigrant workers, either. These facts affect the migrant employment patterns in Japan.

3. Migrant Employment in Japan

3-1. Statistical Trends

The number of immigrant healthcare workers is very small. Statistics issued by the Immigration Bureau of Japan illustrates the trend of immigrant workers. The number of immigrants that have the valid status of residence (visa title “Medical Services”\(^{11}\)) has increased 133 (in 2000) to 460 (in 2011). Most of immigrants come from Asia: in 2011, 256 from China, 60 from Taiwan, 72 from Korea, 24 from Vietnam and 25 from other Asian countries. In contrast to the number of total immigrants, however, the number of new entrants has been less than 10 for these ten years and the number of emigrants usually offsets that of immigrants. These facts indicate that they are, in general, clinical trainees. As for alien registration under the title of "Medical Services", the number has also been around 300 for these ten years (Maximum: 322 in 2011), and 70% of them are from China.

The MHLW records the number of registered medical practitioners and it also hold statistics of foreign-born/nationality practitioners. The numbers of registered physicians, dentists and pharmacists are increasing, but the number of foreign-born/nationality practitioners occupies less than one percent in each practitioners (Chart 4): the number of foreign-born/nationality physicians is around 2,400 in every year; and the numbers of foreign-born/nationality dentists and pharmacists are less than 1,000. Although there is no data for foreign-born/nationality,

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\(^{11}\) This status allows immigrants to practice medical services for one or three years.
the numbers of nurses, midwives and public health nurses have also been increased: in 2010, 953,922 nurses, 169,763 part-time/dispatched nurses, 29,670 midwives, 5,479 part-time/dispatched midwives, 45,028 public health nurses and 6,487 part-time/dispatched public health nurses are registered\(^\text{12}\).

The MHLW also collects data where they practice and what kind of roles they are playing. Statistics shows that foreign-born/nationality practitioners play the same role as local practitioners. In the case of physicians, both local and foreign-born/nationality practitioners tend to be working staffs at hospitals, founders/presidents of clinics and staffs of medical schools (Chart 5). The tendency has not drastically changed for these ten years. Similar to the case of physicians, both local and foreign-born/nationality dentists tend to be founders/presidents of clinics\(^\text{13}\) and working staffs at clinics. In the case for pharmacists, both local and foreign-born/nationality practitioners tend to work at pharmacies or hospitals/clinics and pharmaceutical companies.

When we focus on the distribution of practitioners between urban and rural areas, statistics exhibits that foreign-born/nationality practitioners tend to work in urban areas. For example, foreign-born/nationality physicians tend to practice in populated prefectures such as Tokyo, Osaka, Hyogo, Kanagawa, Kyoto, Chiba, Saitama, Aichi and Fukuoka, regardless the density of local physicians (Figure 1). These prefectures hold heavily populated (over 500,000) cities and national universities that have medical/pharmaceutical/nursing faculties. The similar trend can be seen in the cases of dentists and pharmacists. Japan still has many areas with no physicians and dentists, but foreign-born/nationality practitioners usually do not work in such areas. Figure 3 shows how many persons live in areas with no physicians in each prefecture. The thickness of color on the map stands for the number of people who suffer from shortage of physicians: the thicker a prefecture is painted, the prefecture holds many persons who reside in areas with no physicians. The number printed in each prefecture stands for the number of foreign-born physicians in each prefecture. The figure exhibits that foreign-born/nationality workers are not the solution for the staff shortage, currently.

As outlined above, there have been very few registered foreign-born/nationality staffs in Japan. Their employment patterns have not changed for these ten years, either: they tend to work at urban areas and play the same role as local/Japanese practitioners. When we consider the MHLW’s position (require foreign workers to be qualified by Japan’s national examination and to be fluent in Japanese) and these


\(^{13}\) The fact implies that they tend to be independent and self-employed dentists.
statistical facts, we can conclude that most of foreign-born practitioners are the second-, third-, and fourth-generations of Korean and Chinese who are educated in Japan. Thus, their working patterns are the similar to those of local practitioners: They cannot be a solution for local staff shortage, un-fulfillment of local practitioners and imbalanced distribution between areas.

3-2. Attempts to Invite Oversea Practitioners under Bilateral Agreements

Japan has not accepted immigrant healthcare workers for a long time. However, Japan became faced with both an increase of human mobility in the globalized world as well as the tide of trade liberalization for goods and services. The government and ministries became to be concerned about attracting highly skilled foreign workers. Especially, the MOFA regards the Economic Partnership Agreement (EPA) as a tool for strengthening bilateral economic cooperation with foreign countries. Japan has agreed to arrange special provisions for the movement of natural persons (skilled professionals including nurses and certified care workers) when concluding the EPA with Indonesia and Philippines. The same kind of agreements will be discussed with Vietnam and Thailand.

If we take the arrangement with Indonesia for example, Section 6-1 of Annex 10, which refers to Chapter 7 defines that natural persons who has a purpose of being qualified as nurses under the laws and regulation of Japan, who have been qualified and registered as nurses in Indonesia, and who also have at least two years of nursing experience are allowed to enter and stay in Japan temporarily for one year. That stay may be extended for the same period (one year) not more than twice. Such persons are required to undergo six months of training courses, including a Japanese language course, before practicing at host hospitals/clinics in Japan. They may take the national examination for being qualified as a nurse under Japanese law during their stay (three times, maximum). If they pass the national examination, they can stay and practice in Japan after expiration day of their stay. The similar arrangement was prepared for certified care workers.

The EPA arrangement has attracted practitioners in Indonesia and Philippines,

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15 Ibid.
16 Ibid.
17 The government concluded EPA agreement with Vietnam this year.
19 As for Philippines, three-year practice is required.
20 They are permitted to enter Japan as “designated activity” in visa category.
and candidate nurses and certified care workers came from Indonesia since 2008, and from Philippines since 2009 (Table 1 and 2). However, the results of the national examination were disappointing for them, as well as host hospital/clinics in Japan. In 2009, none passed out of the 87 who took the national examination. Some pointed out that it was hard for the candidates to have practiced reading and understanding Chinese characters (Kanji) that is used in the examination. They also called for the improvement of the preparation course that candidates should take before visiting Japan\textsuperscript{21}. In 2010, 1 Indonesian and 1 Philippines passed the national examination. In 2011, 16 have passed, but it revealed that it is impossible for candidates to pass examination for their first challenges (Table 3). 34 Indonesian and 13 Philippines passed in 2012 (Table 4), but the ratio of success (less than 30\%) is very low, in comparison to the ratio of Japanese applicants (beyond 90\%).

The low ratio of success was the result of conflicting policy interests in a single political arrangement. At the administrative level, the MOFA was for the EPA in order to promote international cooperation through exchanging people (highly skilled workers) on the one hand, the MHLW emphasized that the arrangement in the EPA was not regarded as the solution for staff shortage in the healthcare sector, on the other hand. The MHLW’s position was parallel to the position of the Japanese Nursing Association (JNA)\textsuperscript{22}. The JNA places a special emphasis on protecting the national labor market, on securing safety for medical staff and patients, and on preventing brain drain in source (home) countries. Thus, the JNA declares that it denies the mutual recognition of qualifications. It also strongly requires foreign practitioners to be qualified in Japan (i.e. to pass the national examination) and to be fluent in Japanese language, because nurses engage in medical teamwork at local hospitals/clinics and provide services to local patients\textsuperscript{23}.

Furthermore, the JNA also requires host hospitals/clinics to pay overseas nurses the same wages as Japanese nurses. The “Equal Pay” rule was adopted as the requirement for host hospitals/clinics when they apply for accepting EPA candidate nurses\textsuperscript{24}. The requirement imposes an additional financial burden on the host

\textsuperscript{21} For details of the outcome of the national examination and discussions, see \textit{Asahi Shinbun}, November 2, 2009.

\textsuperscript{22} As for the argument that the government’s position is parallel to the position of the JNA, see Ninomiya (2008), p.152.


\textsuperscript{24} For the details, see http://www.jicwels.or.jp/html/hp_images/h24_tebiki_n.pdf
hospitals/clinics that accept overseas nurses. They are usually faced with severe staff shortage, and they decide to accept nurses through the EPA arrangement with their motivation to secure human resource\(^{25}\). Once they accept EPA candidate nurses, they have to train overseas nurses so that they can get used to Japanese on the job and they can prepare for the national examination. These tasks become practical burdens for host hospitals/clinics. In terms of recruitment, the EPA arrangement is attractive for the host hospitals/clinics, but they soon find that the arrangement bear practical and financial burden on them.

As we can see, government and ministries do not officially admit that they regard the EPA as a solution for the staff shortage, while hospitals/clinics are faced with staff shortages and have a high demand for employees in reality. MHLW’s general policy requires overseas practitioners to be qualified by licenses valid in Japan and to be fluent in Japanese, even if they are already qualified in their home countries. The MHLW does not accept the mutual recognition of qualifications, and does not have procedures to assess the qualifications of overseas nurses, either. Although EPA is bilateral arrangement, it only helps candidates to have opportunities for taking uniform Japanese courses and technical training/practicing and it still requires them to be qualified in Japan. The EPA framework also has a quota: it allows Japan to accept no more than 400 foreign nurses for two years\(^{26}\). These features in the EPA arrangement emphasize that EPA does not aim at increasing the number of immigrant workers. It is natural that such kind of arrangement imposes additional burdens on others, especially on host hospitals/clinics.

3-3. The MHLW’s Position and Actual Employment Situations in the Care Subsector

As shown above, the MHLW reiterates it does not count on immigrant practitioners and the EPA arrangement is a response to international cooperation and trade liberalization, rather than staff shortage. However, MHLW’s human resource plans have not worked so far. For example, its minimum human resource standard such as “150 physicians per 100,000 populations” does not meet the OECD average (3.1 physicians per 1,000 populations in 2010). Japan became aware of international standards such as the


\(^{26}\) For detailed information, see

http://www.mofa.go.jp/mofaj/gaiko/fta/j_asean/indonesia/kango_sdl.html and

OECD Health Data\textsuperscript{27}, and has come to concern the uneven distribution of practitioners between urban and rural areas as well as between clinical departments/areas of excellence. In 2010, the MHLW carried an intensive investigation on the desirable numbers of physicians in each prefecture. The investigation figured out that Japan as a whole requires additionally 10\% of the current number of physicians\textsuperscript{28}. The current possible solution under the Medical Care Act is to increase new entrants to medical schools/faculties/universities. Thus, the MHLW has increased the quota of new entrants since 2008. However, the newest statistics shows that the medical graduates per 100,000 populations have been around 6 persons for these ten years, while OECD average in 2009 is 9.3 persons\textsuperscript{29}. Despite such the statistical evidence, the MHLW expects that the supply of physicians will meet the demand until 2022\textsuperscript{30}.

The current situation for nurses is better than the case of physicians, but Japan also faces the shortage of practicing nurses. In 2010, The MHLW issued the seventh estimation for demand and supply of nursing staffs for the years between 2011 and 2015. The plan did not count on immigrant workers: it planned to increase the numbers of new-graduate nurses, increase the numbers of re-entry into employments and decrease the number of retired nurses\textsuperscript{31} to match the demands. The plan has been working well than in the case of physicians. Nursing graduates per 100,000 populations is around 36 for these ten years, and it is close to the OECD average of 39.7 (in 2009)\textsuperscript{32}.

Under the current Medical Care Law, Japan’s solution for staff shortage is limited: increase of new entrants to medical schools, increase of re-employees and preventing early retirements. However, labor market statistics highlights that it is difficult to match the demand only by mobilizing local license-holders, unless Japan improves the working conditions. Wage in healthcare sector is lower than the average of industries (Chart 6), although the amount itself was improved for these ten years. There is a great wage divergence among the types of occupations such as physicians, nurses, home-helpers/care attendants (Chart 7). Healthcare workers tend to retire earlier due to hard works (including night works) and low wage, in comparison to other industries (Chart 8). When we focus specifically on care workers, a survey conducted by the Care Work Foundation says that 40\% of resigned workers quit working in less than one year,

\textsuperscript{27} For example, see Ministry of Health, Labour and Welfare (2007).
\textsuperscript{28} For example, see Ministry of Health, Labour and Welfare (2011), pp.249-250.
\textsuperscript{29} OECD (2011).
\textsuperscript{30} Ministry of Health, Labour and Welfare (2010).
\textsuperscript{31} Ministry of Health, Labour and Welfare (2006) reported that 10\% of nurses retired in one year.
\textsuperscript{32} OECD (2011).
and another 40% of them work for between 1 to 3 years\textsuperscript{33}. Average length of service is 4 years\textsuperscript{34}. Nearly 23,000 workers are hired annually, but 16,000 resign in the same year\textsuperscript{35}.

However, Japan requires more care staffs than ever: nearly 25% of population is over 65, and 5 millions of people are qualified as long-term care holders. Care workers are highly demanded. In contrast to physicians and nurses, some qualifications/licenses in care subsector are not government certifications, and people can be licensed after completion of courses that contain prescribed lectures and practices. For example, a second-grade license for home helpers/care attendants requires to take about 60 hours of lectures, 42 hours of seminars and 30 hours of practices in average, although the required length of hours are different among schools. People who finished the course are permitted to provide services in home-care works. This license is not a government certification and does not have provisions of nationality. Thus, foreign-born residents, people who enter Japan under spouse visas for example, can take such courses, although they need to have enough language skill to complete the courses. Due to shortage of local workers and failure of mobilizing local license-holders into practice, care businesses begin to hire licensed foreign-born residents: the MHLW reports that the number of foreign-born workers is increasing in care subsector, and the number is from 2,651 in 2009 to 4,491 in 2011\textsuperscript{36}. Although the reports do not show the correlation of data, such as the number of workers, nationality, location of jobs (prefectures), but it is presumed that many of them are residents from China, Philippine, Peru if we find that many private schools start to provide courses for foreign-born people, especially people from these countries. Some local governments start to prepare courses, as one of supports for foreign-born residents. Usually, they support foreign-born residents to take license-courses for free, and also prepare Japanese language courses for free as an introduction for license-courses\textsuperscript{37}.

As discussed above, Japan has not accepted immigrant workers in healthcare sector, although Japan is faced with severe staff shortage, especially in care subsector. Care institutions/facilities, enterprises and foreign-born people come to focus on the fact

\textsuperscript{33} Care Work Foundation (2011), p.93.
\textsuperscript{34} Ibid., p.167.
\textsuperscript{35} Ibid., p.91.
\textsuperscript{37} For example, see http://www.y-hukushijigyo.or.jp/job.html (Accessed on 21 August 2012).
that some licenses in the care subsector are not government certifications, and foreign-born residents are mobilized to labor market. The number of foreign-born workers has rapidly increased. However, they are usually residents in Japan who hold permanent resident or spouse visas. Even foreign-born residents in Japan sometimes need additional introductory courses for Japanese language, in order to complete courses successfully.

4. Alternative Options and Scenarios
This section examines alternative options and scenarios for Japan. As the second section exhibited, this section divides the healthcare sector into two fields, in order to talk about problems to be solved: one field that aims at matching local demands, and the other that aims at developing inbound and outbound businesses.

4-1. Options and Scenarios to Match the Local Demands
Healthcare workers are required not only to be well aware of technical terminologies when communicating with staffs, but also to talk with service recipients plainly and to ease their minds. That’s why the MHLW requires being qualified as well as fluent in Japanese. Japanese language works as an inherent barrier for immigrant workers, as it is not as popularly spoken and studied as English. Such MHLW’s requirements make Japan’s regulatory approach too cautious, and the “full-course” regulation succeeds to protect national labor market as the MHLW wishes/believes in. However, Japan’s regulatory approach is problematic, as even English-speaking countries succeed in controlling immigrant healthcare workers by using bilateral agreements and language barriers.

The UK, for example, was faced with shortage of nurses in the 1990s, and decided to invite foreign nurses in order to increase the number of practicing nurses. The UK concluded bilateral agreements with Philippines and India, and invited thousands of nurses (Table 5). In the 2000s, however, the UK became faced with the oversupply of nurses and financial difficulties to afford practitioners, the government and ministries decided to stop accepting nurses from Philippines and India. The ministries also introduced a new regulatory framework that verifies immigrants’ qualifications and language fluency. It succeeded to decrease the total number of foreign nurses in the UK (Table 4). The UK’s experience exhibits that a bilateral agreement is

38 For the details of the UK’s experiences, see Inoue (2010) and Inoue (2011).
39 In the European Union (EU), the principle of mutual recognition of professional
convenient tool for adjusting the number of foreign workers as the government wishes, and also exhibits that verifying qualifications and language skills\textsuperscript{40} are effective tools for restriction of inflow of foreign workers.

Thus, Japan’s EPA is inconsistent with the usual usage of bilateral agreements. EPA usually aims at increasing exchange of persons, but provisions for nurses and care workers constitute lots of barriers. The Cabinet Office and the MOFA came to concern the number of successful candidates of Japan’s national examination: only 14\% of the candidates of nurses from Indonesia could pass the national examination, even if they stayed and practiced three years in Japan. Although the candidates are qualified practitioners in their home country, they could not be qualified in Japan after working three years. The consequence affected the number of applicants: the number of entrants was halved compared to the first year (Table 1 and 2). In 2011, the Cabinet and the MOFAs made a diplomatic decision that allow the candidates of nurses and certificated care workers to stay one more year\textsuperscript{41}. The MHLW responded passively, and announced a guideline that allows candidate nurses and care workers from Indonesia to practice one more years to be prepared for national examination. The guideline symbolized the Ministry’s attitude: it did not automatically allow the candidates who meet the conditions for additional stay, but required to prepare written forms that assured both candidates’ diligence for the next examination and host hospitals’ clinics’ modified teaching programs\textsuperscript{42}.

In addition, the government decided to print kana readings beside Chinese characters in the examination questions, and the number of success little bit increased. Therefore, language supports are necessary if Japan wants to accept oversea workers.

However, we have to keep in mind that the MHLW officially declares that it won’t accept immigrant workers in this sector. The MHLW emphasizes that it does not take an easygoing action of inviting immigrant workers, although it admits that some claims qualifications prohibits a member state to verify qualifications of practitioners from other member state. The EU also prohibits a member state to regulate free movement of people by nationalities and languages. Therefore, as Table 4 in this paper shows, the inflow from new member states has increased recently.

\textsuperscript{40} Currently, language fluency becomes very easy measure for European governments to restrict inflow of immigrants and promote integration of immigrants to local society. In the latter half of the 2000s, major European countries began to oblige immigrants to take integration courses including language courses.

\textsuperscript{41} Candidates who scored higher ranks (to the 81\textsuperscript{st} candidates including successful applicants) were allowed to stay. For the details, see http://www.mhlw.go.jp/bunya/koyou/other21/dl/o21_1-4-5.pdf (Accessed on February 27, 2012).

\textsuperscript{42} Ibid.
that Japan should invite foreign workers to be prepared for the shortage of workforce in near the future\textsuperscript{43} (emphasis by the author). The MHLW also emphasizes that it promotes involvement of local youths, women, senior generations and handicapped persons, in order to avoid distortion of labor market and wage system by inviting foreign workers\textsuperscript{44}. Of course, it says that it positively promotes recruitment of highly skilled workers and international students of high quality, in order to improve Japan's competitiveness\textsuperscript{45}, but healthcare is not a sector of competitiveness for it. The MHLW refuses to invite immigrant healthcare workers, and emphasizes that staff shortage is to be solved by increasing the numbers of new entrants to medical/nursing schools, by promoting reemployment of early-retired workers, and by attracting students to practicing in the remote and rural areas.

Such the MHLW’s attitude makes it difficult for stakeholders to have open and constructive discussions on immigrant healthcare workers. But, if this paper dares to suggest an alternative scenario, Japan’s experience so far implies that Japan has to improve language supports or to introduce mutual recognition of qualifications/licenses. Especially, in the care subsector, language supports will be a key to match the staff demands. Many foreign-born workers are hired in the care subsector, as they are not necessarily required to have national certifications. They are supposed to complete courses that correspond to the businesses they want to engage in. In such cases, foreign-born workers are only to gain enough language skills to finish the courses. As introduced before, some local governments start to support foreign-born people to have Japanese language courses and complete care-courses. Unless these supports, some of the foreign-born people cannot find jobs and come to need financial support by local governments. Such local governments’ efforts lead to solve the staff shortage in care subsector, empowerment of foreign-born people in our society, and financial burden of local governments. If we collect data for foreign-born workers in this subsector and conduct opinion surveys on them, such data and surveys will give many insights and contribute to the discussions on migrant workers and supply of workforce.

If we agree with the MHLW’s calculation that estimates the supply of workforce will meet the demand in 2022\textsuperscript{46}, and agree with its refusal of accepting immigrant

\textsuperscript{43} For the details, see http://www.mhlw.go.jp/bunya/koyou/gaikokujin18/index.html (accessed on February 27, 2012)
\textsuperscript{44} \textit{Ibid}.
\textsuperscript{45} \textit{Ibid}.
\textsuperscript{46} The National Institute of Population and Social Security Research in Japan expected that population will decrease by 5 to 6 million between 2010 and 2022. http://www.ipss.go.jp/syoushika/tohkei/newest04/gh2401.pdf (Accessed on February 27, 2012). If the MHLW expects the natural decrease of population in calculating the
workers, the alternative options and scenario will be the mobilization of local workers. It is necessary for Japan to work hard to improve working conditions of healthcare workers, especially care workers. However, we have to be in mind that improvement in wage will impose taxpayers or service recipients on additional financial burdens.

4-2. Options and Scenarios to Develop Inbound and Outbound Businesses

Research and development, medical technology, medical devices, pharmaceutical manufacture and nursing-care products are also subsectors in healthcare, and options and scenarios for these subsectors are little bit different from the options and scenarios introduced in the previous subsection: these subsectors usually do not provide direct service to local patients and seniors, and every labor in these sector is not necessarily to be fluent in Japanese. For these subsectors, language barrier is an obstacle to competitiveness, because they lose possible patients and customers in overseas and fail to invite highly skilled workers. Though not systematically developed in the healthcare industries, ministries step forward to invite foreign people for treatment and medical examination as well as their families by improving Japan’s visa policy, and also to bringing up medical translators. Development of such inbound businesses probably requires immigrant/foreign-born staffs that are familiar with Japan’s counterparts.

Outbound businesses may require more immigrant/foreign staffs than inbounds, because Japanese enterprises, hospitals and institutions need supports to start and develop business in foreign markets. These supporting staffs are desirable to be familiar with not only their home countries but also information on Japanese enterprises, hospitals, institutions, products and services, although they are not necessarily to be perfectly fluent in Japanese as practitioners working in Japan are required to be. It is essential for Japan to invite foreign-born/immigrant workers (or students) in order to bring up such supporting staffs, if Japan wants to be competitive in world market. Currently, Japan’s visa policy is favorable for highly skilled immigrants, and individual efforts are developing to bring up foreign workers (students). Japan’s competitiveness in foreign market in this subsector would be encouraged, if ministries and stakeholders cooperate to introduce systematic efforts.

demand and supply of practitioners, there is possibility that the MHLW dares to wait for decrease of population in order to avoid inviting foreign workers due to severe shortage of national workers.
5. Concluding Remarks
Japan enters an era of aging population faster than other developed economies. Rapid increase the number of elderlies triggers both demand for healthcare workers and innovations in healthcare-related products and services. Mobilizing people into healthcare labor market leads to not only match the staff demands but also leads to the growth of the market of healthcare-related products and services: Japan’s experiences as a forerunner of aging population would make Japan gain competitiveness in this sector, in terms of inbound and outbound of healthcare-related products and services.

However, Japan fails to mobilize local workers into healthcare sector so far. It is faced with severe workforce shortage in this sector. In the first place, low birth rate makes it difficult for Japan to secure enough number of medical students. Low wage and hard working hours lead to increase the number of early retirements and latent practitioners, especially in the care subsector. This is why some stakeholders, especially clinics and hospitals, require Japan to invite immigrant/foreign-born workers. The MHLW must achieve satisfactory results of supplying enough local workforces, if it adheres to emphasize that Japan does not need immigrant workers.

Japan is strongly recommended to make early, close and realistic examinations of accepting foreign-born workers, as Japanese language will constitute a barrier for immigrants and it will take much time to attract immigrants than other English-speaking countries. The experiences of EPA and care subsectors prove that it is essential to support foreign-born workers to learn Japanese, although different kinds of language-learning supports would be required between the case for mobilizing foreign-born residents in Japan and the case for inviting practitioners from overseas. Further research on other non-English speaking countries’ efforts would bring us many insights, when Japan officially decides to mobilizing foreign-born residents or inviting immigrants into domestic labor market.
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(Available at http://www.oecd.org/health/healthdata)

[Charts and Figures]

Chart 1: Percentages of people aged 65 and over in major OECD countries

Chart 2: Population by age in Japan: 1947-2060 (estimated)

Chart 3: The numbers of employed persons by industry

Source: Statistical Survey Department, Statistics Bureau, Ministry of Internal Affairs and Communications, Annual reports on the labour force survey.
Chart 4: Numbers of registered practitioners in Japan (Total registration and Foreign-born/nationality)

Chart 5: Ratio of roles that are played by registered physicians in 2010

Chart 6: Comparison of remuneration by industry, and the number of workforce (2010)

Chart 7: Divergence of wages between occupations and sex in the healthcare sector

Chart 8: Comparison of retention by industry, and the number of workforce (2010)

Figure 1: Physicians per 1,000 inhabitants and the number of foreign physicians

Figure 2: Nurses per 1,000 inhabitants

Figure 3: Areas with no physicians (2009) and the number of foreign physicians (2010)

Table 1: Accepted Candidates for nurses and certified care workers by the EPA arrangement: Indonesian case

<table>
<thead>
<tr>
<th>Year</th>
<th>Candidate for Nurses</th>
<th>Candidate for Certified Care Workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>104</td>
<td>104</td>
<td>208</td>
</tr>
<tr>
<td>2009</td>
<td>173</td>
<td>189</td>
<td>362</td>
</tr>
<tr>
<td>2010</td>
<td>39</td>
<td>77</td>
<td>116</td>
</tr>
<tr>
<td>2011</td>
<td>47</td>
<td>58</td>
<td>105</td>
</tr>
<tr>
<td>2012</td>
<td>29</td>
<td>72</td>
<td>101</td>
</tr>
</tbody>
</table>


Table 2: Accepted Candidates for nurses and certified care workers by the EPA arrangement: Philippines case

<table>
<thead>
<tr>
<th>Year</th>
<th>Candidate for Nurses</th>
<th>Candidate for Certified Care Workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>93</td>
<td>217</td>
<td>310</td>
</tr>
<tr>
<td>2010</td>
<td>46</td>
<td>82</td>
<td>128</td>
</tr>
<tr>
<td>2011</td>
<td>70</td>
<td>61</td>
<td>131</td>
</tr>
<tr>
<td>2012</td>
<td>28</td>
<td>73</td>
<td>101</td>
</tr>
</tbody>
</table>


Table 3: Results of the national nurse examination in 2011: Under the EPA arrangement

<table>
<thead>
<tr>
<th></th>
<th>Indonesian</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicants</td>
<td>Successful candidate</td>
<td>Ratio of success</td>
<td>Applicants</td>
<td>Successful candidate</td>
<td>Ratio of success</td>
</tr>
<tr>
<td>Entrants in 2008</td>
<td>91</td>
<td>13</td>
<td>14.3%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Entrants in 2009</td>
<td>159</td>
<td>2</td>
<td>1.3%</td>
<td>74</td>
<td>1</td>
<td>1.4%</td>
</tr>
<tr>
<td>Entrants in 2010</td>
<td>35</td>
<td>0</td>
<td>0%</td>
<td>40</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 4: Results of the national nurse examination in 2012: Under the EPA arrangement

<table>
<thead>
<tr>
<th></th>
<th>Indonesian</th>
<th></th>
<th></th>
<th>Philippines</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicants</td>
<td>Successful candidate</td>
<td>Ratio of success</td>
<td>Applicants</td>
<td>Successful candidate</td>
<td>Ratio of success</td>
</tr>
<tr>
<td>Entrants in 2008</td>
<td>27</td>
<td>8</td>
<td>29.6%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Entrants in 2009</td>
<td>152</td>
<td>22</td>
<td>14.5%</td>
<td>60</td>
<td>9</td>
<td>15.0%</td>
</tr>
<tr>
<td>Entrants in 2010</td>
<td>33</td>
<td>3</td>
<td>9.1%</td>
<td>39</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>Entrants in 2011</td>
<td>41</td>
<td>0</td>
<td>0%</td>
<td>59</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Entrants in 2008 (returnee)</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: http://www.mhlw.go.jp/stf/houdou/2r985200000267jc-att/2r985200000267l2.pdf
(Accessed on 21 August, 2012)
Table 5 Registration of nurses (Initial Registration)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Registration</td>
<td>17,954</td>
<td>21,418</td>
<td>25,123</td>
<td>30,693</td>
<td>31,775</td>
<td>34,617</td>
<td>33,257</td>
<td>31,402</td>
<td>27,704</td>
<td>25,864</td>
</tr>
<tr>
<td>Nurses from overseas (Except EEA* countries)</td>
<td>3,568</td>
<td>5,967</td>
<td>8,414</td>
<td>15,064</td>
<td>12,757</td>
<td>14,122</td>
<td>11,477</td>
<td>8,709</td>
<td>4,830</td>
<td>2,309</td>
</tr>
<tr>
<td>(From Philippines)</td>
<td>(52)</td>
<td>(1,052)</td>
<td>(2,296)</td>
<td>(7,235)</td>
<td>(5,593)</td>
<td>(4,338)</td>
<td>(2,521)</td>
<td>(1,541)</td>
<td>(673)</td>
<td>(249)</td>
</tr>
<tr>
<td>(From India)</td>
<td>(30)</td>
<td>(96)</td>
<td>(289)</td>
<td>(994)</td>
<td>(1,830)</td>
<td>(3,073)</td>
<td>(3,690)</td>
<td>(3,551)</td>
<td>(2,436)</td>
<td>(1,020)</td>
</tr>
<tr>
<td>Nurses from EEA* countries</td>
<td>1,412</td>
<td>1,416</td>
<td>1,295</td>
<td>1,091</td>
<td>802</td>
<td>1,033</td>
<td>1,193</td>
<td>1,753</td>
<td>1,484</td>
<td>1,872</td>
</tr>
<tr>
<td>(From Poland**)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(133)</td>
<td>(442)</td>
<td>(578)</td>
<td>(456)</td>
</tr>
<tr>
<td>(From Czech Republic**)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(23)</td>
<td>(65)</td>
<td>(66)</td>
<td>(52)</td>
</tr>
<tr>
<td>(From Romania***)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(57)</td>
<td>(382)</td>
<td></td>
</tr>
<tr>
<td>(From Bulgaria***)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(25)</td>
<td>(168)</td>
<td></td>
</tr>
</tbody>
</table>


*EEA*: European Economic Area. This category includes both member states of the European Union and some EFTA members.

**Poland and Czech Republic**: Examples as countries that enter the European Union since 2004. Fundamentally, professional practitioners from the EU member states can allowed moving to another member states without verification of qualifications and language tests.

***Romania and Bulgaria**: Examples as countries that enter the European Union since 2007.