Healthcare: Japan’s case

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Outline

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1. Outlines of Japan’s Healthcare Sector

- **Small expenditure on healthcare**
  - Total expenditure on health is 8% of GDP (2008) ⇔ US (16%)
  - 2,878 USD per capita (2008) ⇔ 3,101 USD (OECD avg.)

- **But, rapid demographic change toward aging population** (Chart 1)
  - Population over 65 exceeds 20% of the total population
    * the pace is faster than any other OECD countries
  - The number of people that are authorized to receive long-term care has reached to 5 million (4% of the total population)

- **Employment in healthcare sector increased, but supply does not match the demand**
  * the number of un-fulfillment of job offers increased (36.8 thousands)

- **Staff shortage**
  - Practicing physicians and nurses are fewer than OECD average
  - High rate of leaving-jobs in care works
2. Different Positions, Interests and Policies between Ministries

- **Cabinet Office - “New Growth Strategy”**
  - Considers that healthcare is a **growth market** that holds **103 trillion yen** and **280 thousands of jobs**
  - Urges to promote R&D and to boost overseas sales of products and services

- **Ministry of Economy, Trade and Industry (METI)**
  - Considers that healthcare is a **growth and competitive industry**
  - Promotes **inbound** businesses (e.g., accepting foreign patients and their families)
  - Promotes **outbound** businesses (e.g., outreach of medical institutions and export of equipment/devices, medicines and services by promoting human exchanges)

- **Ministry of Foreign Affairs (MOFA)**
  - Considers that **trade liberalization** is inevitable and promotes to accept overseas skilled workers
    => strongly support for EPA arrangement (see the next section for the details)

- **Immigration Bureau**
  - Aims at inviting highly skilled workers to stimulate **competitiveness** (especially in R&D)
    => introduction of new point-based system

- **Ministry of Health, Labour, and Welfare (MHLW)**
  - **Major regulatory body** in this sector (registration, activities, and human resource planning)
  - Emphasizes that staff demand can be matched by mobilizing **local** workers, and **does not count on immigrant workers**
2. Different Positions, Interests and Policies between Ministries (cont.)

- The MHLW does not allow immigrant workers to practice in Japan, unless they are qualified as professional practitioners by Japan’s national examination
  - Before an immigrant worker takes examinations, his/her language fluency is examined
  - Japanese-Language Proficiency Test (Grade N1) is required to pass, if immigrants are not educated in Japan (junior-high and high schools)
  - Thus, it is difficult for immigrants to pass the exams and practice in Japan

- Findings in this section:
  - The MHLW does not see the healthcare as the sector of competitiveness, in contrast to other ministries such as the Cabinet Office and METI
  - There are two ways of understanding for competitiveness in this sector:
    - To supply enough workforces to match local demands
    - To enhance inbound and outbound business activities through technical cooperation and human exchanges
  - However, the MHLW does not count on immigrant workers, and its position conflicts with MOFA, Cabinet Office and METI
  - These facts influence on the migrant employment patterns in Japan -> the next section
3. Migrant Employment in Japan: 3-1. Statistical Trends

• Statistics by Immigration Bureau
  – Immigrants under the visa title “medical services”: 460 in 2011
  – Alien registration: 322 in 2012
  – Most of them from Asian countries, especially from China and Korea

• Statistics by the MHLW
  – Around 2,400 foreign-born physicians, 1,000 foreign-born dentists, 1,000 foreign born pharmacists register in Japan (Chart 4) => less than 1% of total practitioners
  * no data for nurses and midwives
  – Foreign-born practitioners tend to play the same role as local workers (e.g. working staff in hospitals, presidents of clinics: Chart 5)
  – Foreign-born practitioners tend to practice in the same areas as local workers (urban areas: Figure 1 for example)

• Findings in this subsection:
  – Most of foreign-born practitioners are people who are educated in Japan (the second-, third- and fourth-generations of Korean and Chinese)
  – They cannot be a solution for local staff shortage, un-fulfillment of local practitioners and imbalanced distribution between urban and rural areas
3. Migrant Employment in Japan: 3-2. Attempts to Invite Oversea Practitioners under EPA

Japan concluded the EPA (Economic Partnership Agreement) with Indonesia and Philippines and began to accepting candidate nurses/care workers temporally.

- EPA Candidates should have at least two-years practicing experiences in their home countries
- Their length of stay is one year, and can be extended not more than three times
- They have to pass national exam in Japan, if they want to stay and practice after their expiration date
- Hundreds of candidates enter and practice in Japan, but most of them cannot pass the exams (Table 1 and 3), due to difficulty to read Japanese, especially technical terms written in Kanji (Chinese characters)
- Problems in EPA arrangement: Conflicting ministries’ interests in a single policy
  - The MOFA sees the EPA as a tool for enhancing international cooperation
  - The MHLW emphasizes that the EPA is not a policy to solve staff shortage
  - The Japan Nursing Association and the MHLW requires “Equal Pay” to EPA candidates => imposes (financial and educational) burdens for accepting hospitals/clinics
- The government allowed additional stay (one year) and putting kana readings to Kanji => Succeed to increasing the number of success (34 Indonesian and 13 Philippines)
- Findings: Language support is essential, if Japan wants to invite immigrant workers

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3. Migrant Employment in Japan:
3-3. The MHLW’s Position and Actual Employment Situations in Care Subsector

• The MHLW’s position and reality
  – The MHLW does not count on foreign practitioners
  – However, the MHLW fails to mobilize local practitioners including students and latent practitioners, and Japan is faced with shortage of physicians and nurses, in comparison to OECD average
  – It is difficult to hire local workers especially in care subsectors, due to low wage (Chart 6 and 7) and short length of practicing years (Chart 8)
    * Average length of working year in care subsector is four

• Increase the number of foreign-born workers in care subsector
  – The number is from 2,651 in 2009 to 4,491 in 2011 (MHLW)
    * Many of them are people from Philippines, China and Peru who have, permanent and spouse visas
  – In contrast to physicians and nurses, they can have licenses after completing care-work courses that contains prescribed hours of lectures, seminars and practices
  – Some local governments start to help them to take Japanese language course for free, and promote them to take care courses so that they can get jobs

• Findings:
  – Despite the MHLW’s position and estimation, staff shortage is severe especially in care subsector
  – The number of foreign-born workers rapidly increase in care subsector
  – Local governments (and private schools and entities) begin to support foreign-born workers to take care-work courses, and support them to have enough language skill to complete the courses

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4. Alternative Options and Scenarios: 4-1. Options and Scenarios to Match the Local Demands

The MHLW’s requirement (to be qualified in Japan and be fluent in Japanese) has persuasiveness, because healthcare workers have to communicate with both local skilled co-workers and local patients/service recipients. However, the MHLW fails to supply enough local workers to match local demands, so far.

Therefore, two ways of options and scenarios are possible:

• The MHLW exhibits satisfactory results of supplying local staffs, if it adheres to local workers
  – But, it is inevitable to improve local working conditions, especially wages in care subsectors. It may impose additional financial burden to taxpayers.

• Experiences of EPA and care subsector indicate that Japan has to improve language supports or to introduce mutual recognition of qualifications/licenses
  – Language supports are essential, as Japanese is not popularly studied and spoken as English
  – Need to remove language barrier for immigrants, if Japan wants to invite immigrant workers and it does not want to be at a disadvantage in inviting them

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

- In contrast to the previous subsection, inbound and outbound businesses -such as R&D, medical technology, medical devices, pharmaceutical manufacture and nursing-care products- 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
  - Inbound businesses probably requires immigrant/foreign-born staffs that are familiar with Japan’s counterparts
  - Outbound businesses may require more immigrant/foreign staffs to enter international markets, and such 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 to communicate with local Japanese

Therefore, options and scenarios would be:

- To open the doors to foreign patients and families (inbound) as well as foreign students and workers (outbound) by improving visa policies
- To bring up people to bridge Japan and its counterparts so that they support inbound and outbound businesses, by promoting human exchanges and technical cooperation
  - Systematic efforts by stakeholders are required, beyond individual efforts by individual organization
5. Concluding Remarks

• Rapid aging population in Japan triggers both demand for healthcare workers and innovations in healthcare-related products and services

• Mobilizing people into 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 as well as Japan’s competitiveness

• However, Japan fails to mobilize local workers into healthcare sector so far
  – Some stakeholders urge to invite immigrant workers
  – The MHLW must achieve satisfactory results of supplying enough local workforces, if it adheres to emphasize that Japan does not count on immigrant workers

• The experiences of EPA and care subsectors prove that it is essential to support foreign-born workers to learn Japanese

• 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
Thank you very much for your attention!!
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Chart 1: Percentages of people aged 65 and over in major OECD countries
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
Figure 1: Physicians per 1,000 inhabitants and the number of foreign physicians

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

Table 3 (right): Results of the national nurse examination in 2011: Under the EPA arrangement (Indonesian candidates)

<table>
<thead>
<tr>
<th>Year</th>
<th>Candidate for Nurses</th>
<th>Candidate for Certified Care Workers</th>
<th>Total</th>
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<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>
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<tr>
<td>2010</td>
<td>39</td>
<td>77</td>
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<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>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Applicants in 2008</th>
<th>Successful candidate</th>
<th>Ratio of success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrants</td>
<td>91</td>
<td>13</td>
<td>14.3%</td>
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<td>in 2008</td>
<td></td>
<td></td>
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<tr>
<td>Entrants</td>
<td>159</td>
<td>2</td>
<td>1.3%</td>
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<tr>
<td>in 2009</td>
<td></td>
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<tr>
<td>Entrants</td>
<td>35</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>in 2010</td>
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</tbody>
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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)

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