Healthcare: The case of Japan[±]

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Abstract

Japan requires all of the healthcare practitioners to be qualified by national examinations and to be fluent in Japanese. Consequently, the number of immigrant workers remains very low, although Japan is faced with staff shortage. Even under the special bilateral arrangement that allows nurses and certified care workers from Indonesia and Philippines to practice temporally, there are very few who passed the Japan's national examination: it is difficult for them to read technical terms written in Japanese, especially written in Chinese characters (Kanji). In care subsector, where wage is lower than physicians and nurses and qualifications/licenses are not necessarily required, the number of employed foreign-born residents is rapidly increased. Some local governments have started to support them to complete language and care-work courses. These facts show that language support is necessary if Japan considers that matching local staff demands is important for competitiveness. If Japan considers that development of inbound and outbound business leads to competitiveness, it is necessary for Japan to introduce systematic efforts to bring up foreign-born staffs, but language fluency requirement is not necessary in accepting foreign-born workers.

Keywords: Aging population, staff shortage, inbound and outbound businesses, Economic Partnership Agreement (EPA), language support.

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. Especially, Japan enters the era of aging population more rapidly than any other OECD countries, and it 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 statistical 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 ways of understanding of "competitiveness": the one is increasing the number of workforce in order to match local staff demands; the other is developing inbound and outbound businesses for healthcare-related industries. The varied and conflicting interests among ministries cur-

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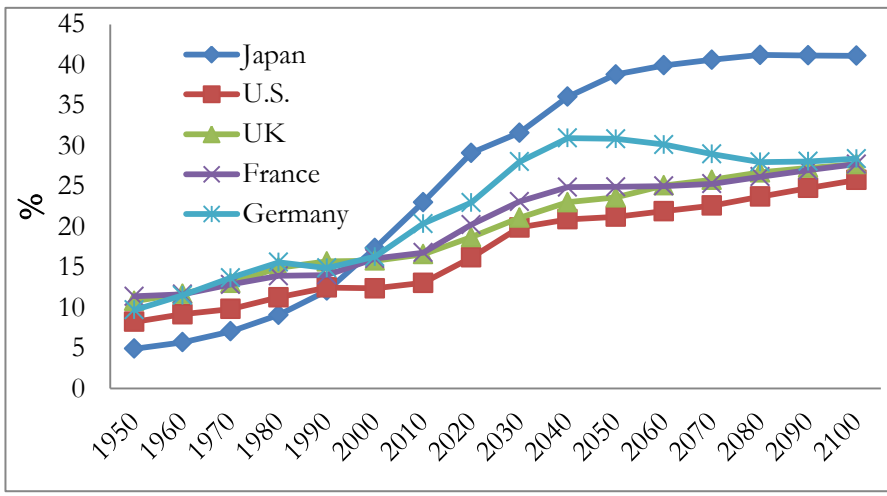
rently make Japan's healthcare sector regulated one. The third section touches on the migrant employment pattern in Japan. It examines the statistical trends of foreign-born workers, and introduces Japan's attempts to invite overseas practitioners under bilateral agreements. It also focuses on the MHLW (Ministry of Health, Labour and Law), the key regulator in this sector, to exhibit its position for accepting foreign-born workers. Then, this section introduces the actual situations in care subsector, to reveal that the MHLW's calculations and human resource plans do not work in reality. The fourth section touches on the alternative options and scenarios for Japan in terms of competitiveness and migration.

Outlines of Japan's healthcare sector

One of the key features of Japan's healthcare sector is its size in the national economy. *The OECD Health Data 2011* reported that Japan's total expenditure on health is 8.5% of gross domestic product (data 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

Figure 1. Percentages of people aged 65 and over in major OECD countries



Source: National Institute of Population and Social Security Research (2012).

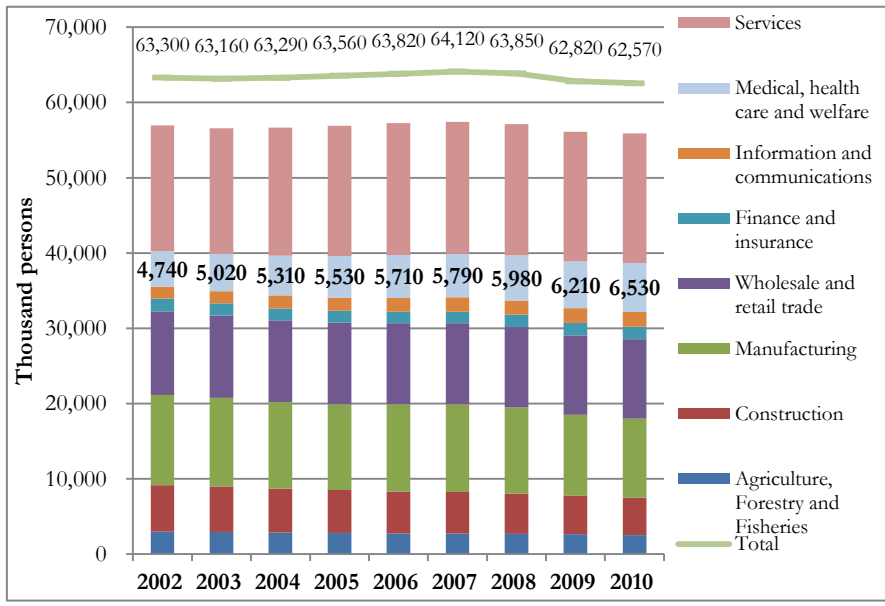
expenditure on health per capita (PPP: purchasing power parity) was 2,878 US dollar, and it was lower than the OECD average (3,101 US dollar). Pharmaceutical expenditure per capita (PPP) was 558.3 US dollar: it was also lower than the OECD average (939.5 US dollar). Such small amount of expenditure is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

When we focus on 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 (Figure 1). Population over 65 has exceeded 20% of the total population, and the percentage is estimated to reach 40% in 2060 (NIPSSR, 2012). In 2012, the number of people that are authorized to receive long-term care has reached to 5 million: it exceeds 4% of the total population.

In response to the demographic trend, the number of employees in the healthcare sector has been increasing, while the numbers are decreasing in other sectors (Figure 2). Healthcare sector becomes a growing labour market now, but there is a big gap between demand and supply of workforce: the number of un-fulfilment of job offers in healthcare sector has also increased from 23.6 thousands in 2005 to 36.8 thousands in 2010, while the numbers have been almost halved in other sectors (MHLW, 2005, 2010d).

Figure 2. The numbers of employee by industry in Japan

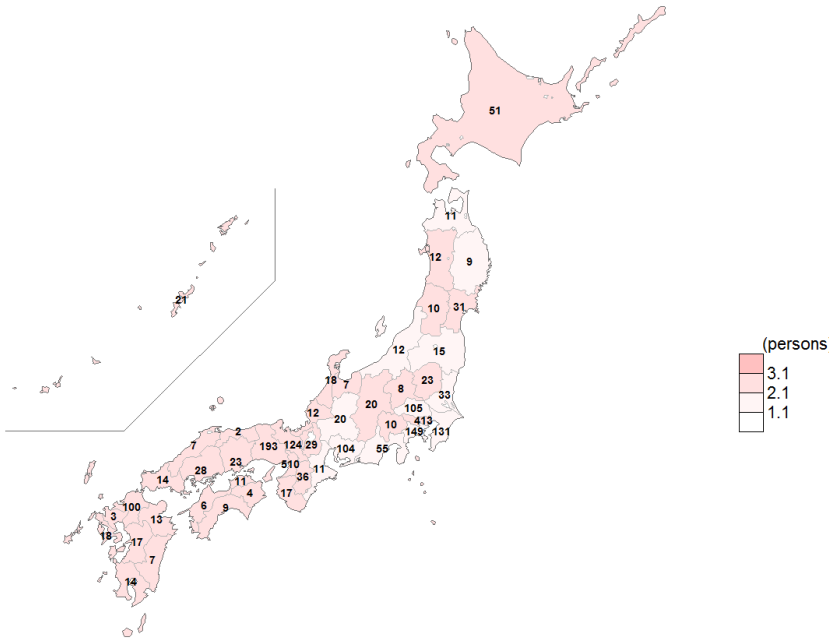


Source: Statistical Survey Department, Statistics Bureau, Ministry of Internal Affairs and Communications (2010).

Staff shortage can be found in every subsector of healthcare. 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 (Map 1). As for nurses, the urban areas, especially prefectures in Kanto district (around Tokyo), are below the OECD average (8.4 nurses per 1,000 inhabitants). The same situation can be found in the long-term care subsector. In response to the aging population, facilities for long-term care need much workforce than ever. An investigation conducted by the Care Work Foundation exhibits that 24% of care facilities use posting workers in order to hire nursing and caring staffs, especially home-visit caring staffs (CWF, 2008:46). 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%: Care facilities have difficulties in hiring alternative staffs (CWF, 2011:90,109,111,112).

Map 1. Physicians per 1,000 inhabitants in Japan



Source: Ministry of Health, Labour and Welfare (2010c).

** The number on the map stands for the number of registered foreign-born physicians.*

In general, shortage of workforce in domestic labour 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 competitiveness and migration in the healthcare sector.

Different positions, interests and policies among ministries

Currently, the government and ministries take different policy approaches within their competences, and they have different views of competitiveness and migration in healthcare sector. The Cabinet Office published a new growth strategy in 2010[1]. The strategy has expected that the healthcare sector would bring Japan a new market of 103 trillion yen as well as 280 thousands of jobs until 2020. In order 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 examina-

[1] http://www.kantei.go.jp/jp/sinseichousenryaku/sinseichou01.pdf (Accessed 18/08/2012).

tion/treatment services. The strategy also proposed an action program that includes changes of 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; some medical institutions start to advertise themselves in these languages; and regulations of foreign practitioners and patients were improved[2].

The Ministry of Economy, Trade and Industry (METI) also considers healthcare as a growth and competitive industry. A committee in charge of healthcare industry has recently begun to consider the development of both inbound and outbound businesses[3]. As for inbound business, it aims at accepting overseas patients and their families where accordingly it is essential to bring up medical translators to accept foreign patients and their families. In also emphasizes that the increase of foreign patients contribute to secure the necessary numbers of cases for technical improvements. As for outbound business, the committee also aims at supporting to establish outreach medical institutions/facilities and also aims at exporting medical equipment and services. To achieve these aims, the committee thinks it essential to exchange human resources, as outbound business requires staffs that are well-acquainted with both target markets/countries and Japan's facilities, institutions, as well as goods and services. Although there is currently no comprehensive project/program that is specifically prepared for healthcare industry, general schemas, 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, have contributed to international technical cooperation and exchanging human resources with Asian countries.

The Ministry of Foreign Affairs (MOFA) has come to concern free trade including human exchanges as a response to economic globalization. It considers it necessary to promote free movement of natural person in terms of trade liberalization, and promotes to accept overseas workers by concluding bilateral agreements (for example, see the Economic Partnership Agreement 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 foreign-born healthcare workers who want to practice in Japan. It is the Ministry of Health, Labour and Welfare (MHLW) that regulates the Japan's healthcare labour market.

[2] For the details, see http://www5.cao.go.jp/keizai2/keizai-syakai/pdf/jitsugen2011.pdf (In Japanese, accessed on August 18, 2012).

[3] http://www.meti.go.jp/topic/data/medical_industry.html, and http://www.meti.go.jp/committee/summary/0004627/000_01_02.pdf (In Japanese, accessed on August 18, 2012).

The MHLW regulates the licenses and qualifications, registration, and activities of medical institutions and practitioners. 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 number of healthcare workers, but the measure does not figure in the immigrant workers. The MHLW emphasizes that the staff demand should be matched by mobilizing local practitioners.

Japan has no bilateral international agreement on mutual and automatic recognition of professional qualifications and licenses in healthcare sector[4]. The MHLW does not allow immigrant workers to practice in Japan unless they are qualified as professional practitioners by Japan's national examination, even if they have been already qualified and being practicing in their home countries. Therefore, immigrant workers, who want to practice in Japan, have to pass Japan's national examinations[5]. If an immigrant worker wants to take the national examination, they have to undergo a review of eligibility requirements for the examination. If he/she is judged to meet the requirements, then his/her language fluency[6] 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 are Chinese or Korean nationality. Such MHLW's regulatory attitude reveals that it 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 the MOFA, the MHLW, the key 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.

[4] 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.

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

[6] The assessment of language fluency expects applicants to exhibit enough language abilities to practice medical examinations and treatments.

Migrant employment in Japan

Statistical trends

In Japan, the number of foreign-born healthcare workers is very small. The Immigration Bureau of Japan reports that the number of immigrants who have the valid status of residence (visa title "Medical Services"[7]) has increased 133 (in 2000) to 460 (in 2011). Most of them come from Asia: in 2011, 256 out of 460 were from China, 60 were from Taiwan, 72 were from Korea, 24 were from Vietnam, and 25 were from other Asian countries. However, the Bureau also reports that the number of new entrants has been less than 10 for these ten years, and the number of emigrants usually offsets the number of immigrants. The Bureau collects the data for foreign-born people that are authorized to reside in Japan. The number of alien registration under the title of "Medical Services" has been around 300 for these ten years (Maximum: 322 in 2011), and 70% of them are from China.

The MHLW, which is in charge of registration of qualified healthcare practitioners, records the number of registered medical practitioners. The numbers of registered physicians, dentists and pharmacists have been increasing, but the number of foreign-born/nationality practitioners occupies less than one per cent in each practitioners (Figure 3): the number of registered foreign-born/nationality physicians is around 2,400 in every year; and the numbers of registered foreign-born/nationality dentists and pharmacists are less than 1,000. The numbers of nurses, midwives and public health nurses have also increased: 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 in 2010, although there is no data for foreign-born/nationality practitioners (MHLW, 2010b).

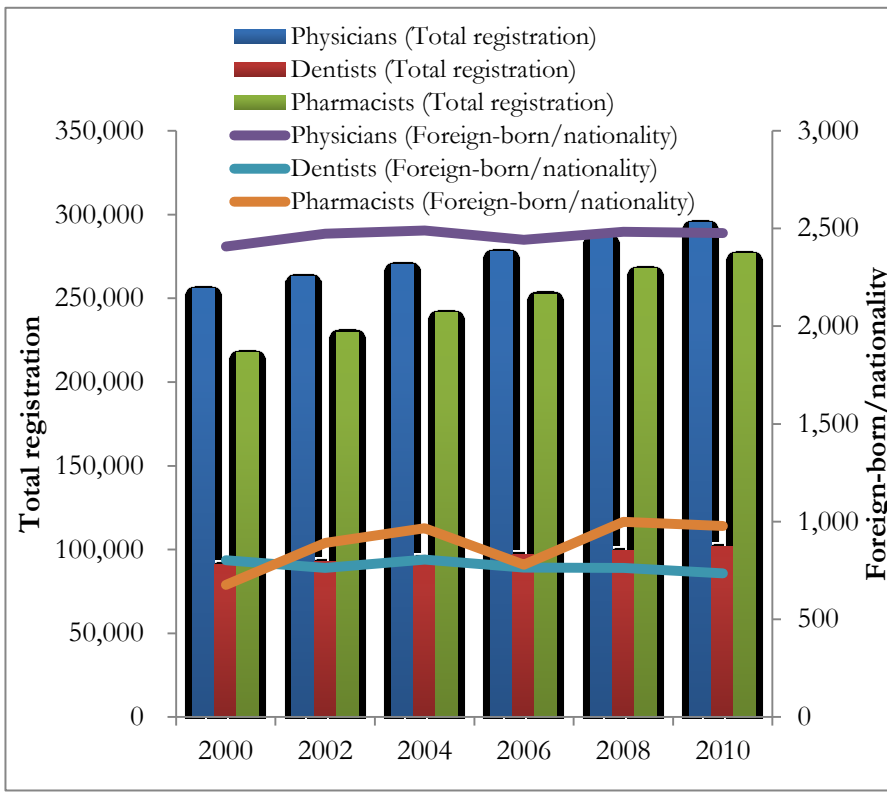
The MHLW also collects data of the roles which they are playing and data of the districts which they are practicing in. As for the roles, statistics shows that foreign-born/nationality practitioners tend to play the same role as local practitioners. In the case of physicians, for example, both local and foreign-born/nationality practitioners tend to be working staffs at hospitals, founders/presidents of clinics and staffs of medical schools (MHLW, 2002, 2004, 2006b, 2008b, 2010c). The tendency has not drastically changed for these ten years. Similar to the case of physicians, local and foreign-born staffs are tend to play the same roles in the cases of dentists and pharmacists: both local and foreign-born/nationality dentists tend to be founders/presidents of clinics[8] and working staffs at clinics; and both local and foreign-born/nationality pharmacists tend to work at pharmacies or hospitals/clinics and pharmaceutical companies (MHLW, 2002, 2004, 2006b, 2008b, 2010c).

[7] This status allows immigrants to practice medical services for one or three years.

[8] The fact implies that they tend to be independent and self-employed dentists.

When we focus on the distribution of practitioners (districts which staffs are practicing in), 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 (Map 1). These prefectures hold heavily populated (over 500,000) cities, and they also hold national universities that have medical/pharmaceutical/nursing faculties. The similar tendency can be confirmed in the cases of dentists and pharmacists (MHLW, 2010b, 2010c). Foreign-born/nationality practitioners do not work in the areas that have no physicians and dentists, either, although Japan still has many areas with no physicians and dentists (MHLW, 2009b). These statistical facts exhibit that foreign-born/nationality workers are not the solution for the local staff shortage, currently.

Figure 3. Numbers of registered practitioners in Japan (Total registration and Foreign-born/nationality)



Source: Ministry of Health, Labour and Welfare (2002, 2004, 2006b, 2008b, 2010c).

As outlined above, there have been very few registered foreign-born/nationality healthcare practitioners 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 that requires foreign workers to be qualified by Japan's national examination and to be fluent in Japanese, together with these statistical facts, we can conclude that most of registered foreign-born practitioners are the second- and third-generations of Korean and Chinese who are educated in Japan. Therefore, their working patterns are the similar to those of local practitioners: They cannot be a solution for local staff shortage, un-fulfilment of local practitioners, and imbalanced distribution between urban and rural districts.

Bilateral agreements to invite foreign-born practitioners: EPA and the MHLW

The MHLW, which is in charge of human resource planning in healthcare sector, does not count on foreign-born practitioners. It denies recognizing licenses and qualifications which are valid in other countries, either. Consequently, Japan has not accepted immigrant healthcare workers for a long time. However, in the globalized world, Japan became faced with both the increase of human mobility in the globalized world as well as the tide of trade liberalization for goods and services (MHLW, 2009a:232-233). The government and ministries became to be concerned about attracting highly skilled foreign-born workers. Especially, the MOFA began to use the Economic Partnership Agreements (EPA), which are bilateral agreements to enhance bilateral economic cooperation with foreign countries. When Japan concluded the EPA with Indonesia and Philippines, Japan agreed to arrange special provisions for the movement of natural persons (skilled professionals including nurses and certified care workers). The same kind of agreements will be discussed with Vietnam and Thailand[9].

If we take the arrangement with Indonesia for example, Section 6-1 of Annex 10, which refers to Chapter 7[10], defines that natural persons who has a purpose of being qualified as nurses under the laws and regulation of Japan, who have also been qualified and registered as nurses in Indonesia, and who also have at least two years of nursing experience[11], are allowed to enter and to be trained in host hospitals/clinics for one year[12]. 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 can 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.

[9] The government concluded EPA with Vietnam in 2012.

[10] http://www.mofa.go.jp/region/asia-paci/indonesia/epa0708/annex10.pdf (accessed on December 14, 2009)

[11] As for Philippines, three-year practice is required.

[12] They are permitted to enter Japan as "designated activity" in visa category.

The EPA arrangement has attracted practitioners in Indonesia and Philippines, and candidate nurses and certified care workers came from Indonesia since 2008, and from Philippines since 2009. However, the results of the national examination were disappointing for both candidates and host hospital/clinics. In 2009, 87 candidate nurses took the national examination, but none of them passed. Some pointed out that it was hard for the candidates to have practiced reading 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[13]. In 2010, 1 Indonesian and 1 Philippines passed the national examination. In 2011, 15 Indonesian and 1 Philippines have passed. In 2012, 34 Indonesian and 13 Philippines passed. These results reveal that it is impossible for candidates to pass examination for their first challenges, although they are already qualified in their home countries. The ratio of success is very low, if we compared to the ratio of Japanese applicants (beyond 90%).

The low ratio of success is the result of conflicting policy interests in a single political arrangement. At the administrative level, the MOFA and the MHLW take the different positions to the EPA. The MOFA thinks that the EPA contributes to the international exchange of persons and inviting highly skilled persons. However, the MHLW emphasized that the EPA was not regarded as the solution for local staff shortage. Such MHLW's position was parallel to that of the Japanese Nursing Association (JNA), one of the occupational interest group in the healthcare sector[14]. The JNA places a special emphasis on protecting the national labour market, on securing safety for staff and patients, and on preventing brain drain in source (home) countries. Therefore, the JNA strongly requires foreign-born 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 and provide services to local patients[15]. Of course, it strongly denies the mutual recognition of qualifications that may promote international mobilization of healthcare practitioners.

Furthermore, the JNA requires host hospitals/clinics to pay foreign-born nurses the same wages as local nurses. Host hospitals/clinics are required to obey the "Equal Pay" requirement, before they apply for accepting candidate nurses[16]. Therefore, for the host hospitals/clinics, EPA candidates cannot be cheaper (wage) workers. On the contrary, accepting candidates imposes additional burdens on the host hospitals/clinics. Once they accept EPA candidates, they have to train them so that they can get used to Japanese on the

[13] For details, see *Asahi Shinbun*, November 2, 2009.

[14] As for the argument that the government's (MHLW's) position is parallel to the position of the JNA, see Ninomiya (2008), p.152.

[15] For the position held by the Association, see for example http://www.nurse.or.jp/home/opinion/press/2008pdf/0617-4.pdf and http://www.nurse.or.jp/home/opinion/newsrelease/2006pdf/20060912.pdf (printed in Japanese, accessed on December 14, 2009).

[16] http://www.jicwels.or.jp/html/hp_images/h24_tebiki_n.pdf (Accessed 24/02/2012).

job. They also have to help candidates to be prepared for the national examination, if they want candidates to stay longer. These tasks become practical burdens for host hospitals/clinics. Consequently, we can conclude that the EPA is not arranged for host hospitals/clinics that want to employ foreign-born workers due to local staff shortage. The EPA is arranged only for hospitals/clinics that are prepared to bear both practical and financial burdens[17].

Fundamentally, EPA is a bilateral agreement on economic and trade partnership. In such a nature, it should works for trade liberalization or de-regulation in order to stimulate inflow of goods, persons, and services from Japan's counterpart, even though the liberalization and de-regulation are partial and conditional ones. However, as we can see above, the EPA arrangement is neither a policy to invite foreign-born practitioners, nor a solution for local staff shortage. Japan's EPA constitutes various regulatory and operational barriers: it has a quota and it allows Japan to accept no more than 400 foreign-born nurses for two years[18]; EPA candidates cannot extend their stay, unless they pass Japan's national examination; and host hospitals/clinics have to be prepared for financial and practical burdens. Ironically, these barriers have worked well so far. The number of candidates extremely decreased in 2010, and it has not been exceeded 100 for 3 years.

Such a cautious approach in the EPA is influenced by the MHLW's principle and assumption. It requires foreign-born practitioners to be qualified in Japan and to be fluent in Japanese, it denies the mutual recognition of qualifications, and it denies counting on foreign-born staffs. Does Japan's status quo support the MHLW's assumption and principle? In other words, does the MHLW succeed in matching demand and supply of workforce? Does the MHLW's assumption that Japan does not count on foreign-born practitioners work in reality? The next subsection addresses to these questions.

Assumption, calculation, and expectation of the MHLW and actual employment situations

MHLW's human resource plans have not worked so far. For example, it sets a minimum standard for the number of physicians as "150 physicians per 100,000 populations", but this does not meet the OECD average (3.1 physicians per 1,000 populations, data in 2010). Japan has recently become aware of international statistical standards such as the *OECD Health Data* (MHLW, 2007), and has come to concern the uneven distributions of practitioners between districts as well as between clinical departments/areas of excellence.

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[17] MHLW's investigations shows that beyond 80% of the host hospital/clinics decide to accept EPA candidates in order to be prepared to international contribution (people exchange), and it is 48% of them that accept EPA candidates for the solution of staff shortage. www.mhlw.go.jp/stf/houdou/2r9852000000054my-img/2r985200000054pi.pdf (Accessed 5/1/2012).

[18] For the details, see www.mofa.go.jp/mofaj/gaiko/fta/j_asean/indonesia/kango_sdl.html and http://www. mhlw. go.jp/ bunya/koyou/other21/index.html (Accessed 14/12/2009). See also *Journal of Care Management, Monthly* 19:11 (2008), pp.10-11.

Thus, 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 demands 10% of additional number of physicians (MHLW, 2011:249-250). The current possible solution under the Medical Care Act is to increase new entrants to medical schools, faculties, and universities. The MHLW has already taken the options, and has increased the quota of new entrants since 2008. However, the newest statistics shows that the medical graduates per 100,000 populations have still been around 6 persons, while OECD average is 9.3 persons (data in 2009) (2011). Despite such the statistical evidence, the MHLW estimates that the supply of physicians will meet the demand until 2022[19].

Japan is also faced with the shortage of practicing nurses, although the situation is better than the case of physicians. 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. Rather, it attempts to increase the numbers of new-graduate nurses, increase the numbers of re-entry into employments, and decrease the number of retired nurses[20]. The plan has been working well than the case of physicians, and nursing graduates per 100,000 populations is around 36, and it is close to the OECD average of 39.7 in 2009 (OECD, 2011).

Under the current Medical Care Law, MHLW's solution for staff shortage is very limited: increasing the number of new entrants to medical schools; promoting re-employments; and preventing early retirements. However, labour market statistics highlights that it is unlikely to mobilize local license-holders without improving working conditions. For example, wage in healthcare sector is lower than other industries (Figure 4). Within the healthcare sector, there is a great wage divergence among the types of occupations such as physicians, nurses, and home-helpers/care attendants (Figure 5). Healthcare workers tend to retire earlier due to hard works (including night works) and low wage, in comparison to other industries (Figure 6). When we focus specifically on care workers, a survey conducted by the Care Work Foundation reports that 40% of resigned workers quit working in less than one year, and another 40% of them quit in between 1 to 3 years (CWF, 2011:29). In care subsector, average length of service is 4 years (CWF, 2011:167). Nearly 23,000 workers are hired annually, but 16,000 resign in the same year (CWF, 2011:91). It is inevitable to improve working conditions if Japan wants to mobilize local practitioners into practice.

Despite the MHLW's optimism about matching the demand and supply of workforce, the supply of workforce has become a matter requiring immediate

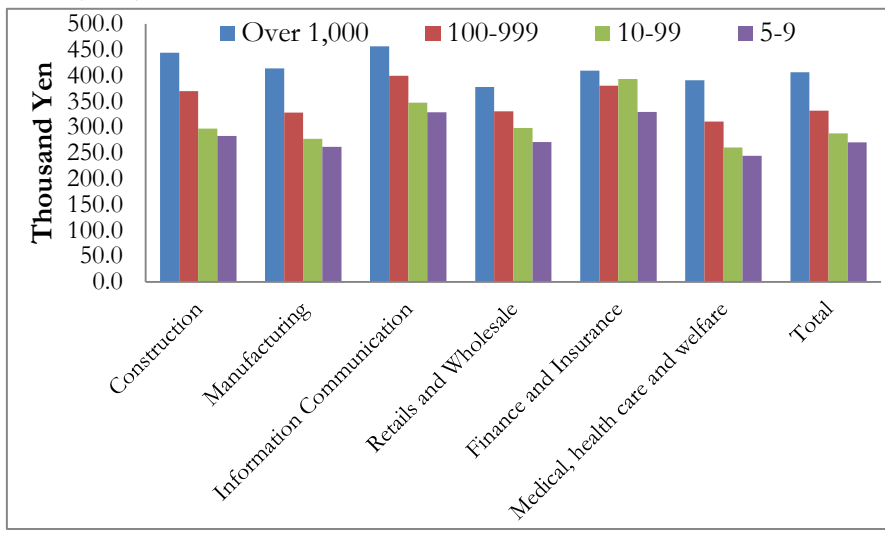
[19] MHLW (2008a), p.47. The National Institute of Population and Social Security Research expected that population will decrease by 5 to 6 million between 2010 and 2022. http://www.ipss.go.jp/syoushika/tohkei/newest04/gh2401.pdf (printed in Japanese, accessed on February 27, 2012). It implies that the MHLW counts on the natural decrease of population in calculating the demand and supply of practitioners.

[20] MHLW (2006a) reported that 10% of nurses retired in one year.

attention. In Japan, nearly 25% of population is over 65 years old, and 5 millions of people are qualified as long-term care holders. Japan needs more healthcare workers than ever, especially in care subsector.

In contrast to physicians and nurses, many qualifications/licenses in care subsector are not government certifications. 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 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 have completed the course are permitted to provide services in home-care works. This license is not the government certification, and it does not have provisions of nationality, either. Therefore, foreign-born residents, people who enter Japan under spouse visas for example, can take such courses, although they need to have enough Japanese language skill to complete the courses.

Figure 4. Comparison of remuneration by industry, and the number of workforce (2010)



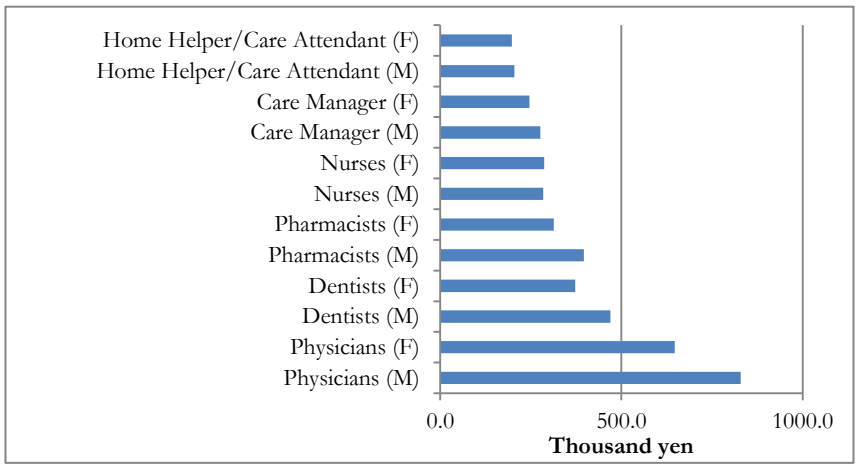
Source: Ministry of Health, Labour and Welfare (2010a).

Due to shortage of local care workers and failure of mobilizing local license-holders into practice, care businesses begin to hire foreign-born residents: the MHLW reports that the number of foreign-born workers is rapidly increasing in care subsector, and the number is from 2,651 in 2009 to 4,491 in 2011[21]. Although the reports do not show the correlation of data (e.g. correlation between the number of workers, nationality, location/district of practice),

[21] MHLW, *press releases* (printed in Japanese) "Gaikokujin-Koyou no Todokede Joukyou (Status quo of notification of hiring foreign-born workers)". Since 2007, under the Employment Countermeasures Act, The MHLW requires every president of care-business/enterprise to report the MHLW when he/she hires/fires foreign-born workers.

but it is presumed that many of them are residents from China, Philippine, Peru, as many private schools start to provide courses for foreign-born people from these countries. Some local governments start to support foreign-born residents to take license courses for free, and some of them also prepare Japanese language courses before taking license-courses[22].

Figure 5. Divergence of wages between occupations and sex in the healthcare sector



Source: Ministry of Health, Labour and Welfare (2010a).

As discussed above, statistics reveals that Japan fails to supply enough local staffs, however strongly the MHLW emphasizes its assumptions, calculation, and expectations. Supply of physicians and nurses are below the OECD average, and the policy options provided by the Medical Care Act do not contribute to mobilize local practitioners. In care subsector, in which practitioners are not required to national qualifications, the number of employed foreign-born residents has been increased. Some local governments have started to help foreign-born residents to be employed in care subsector. Under such situations, what will Japan's alternative options and scenarios be? The next section addresses to the question.

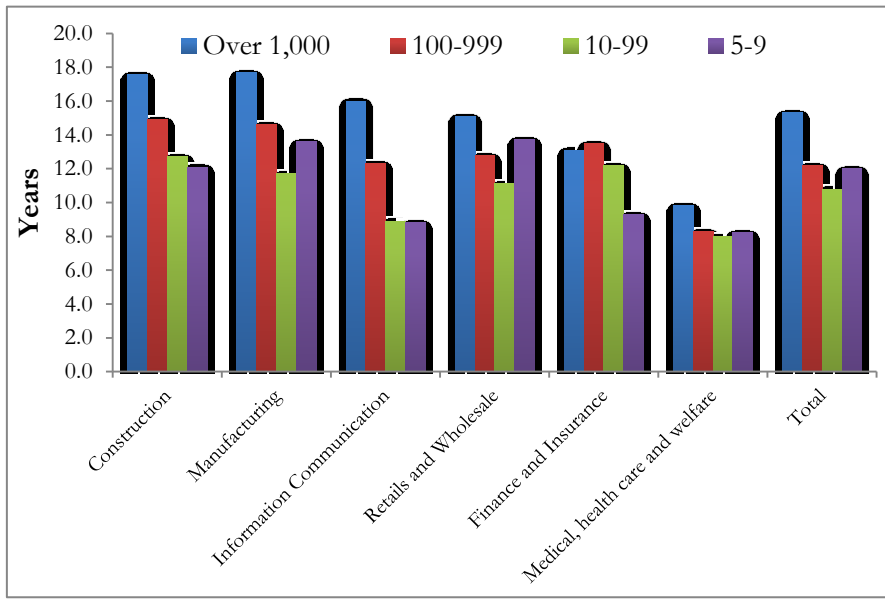
Alternative options and scenarios

As the second section has outlined, government and ministries exhibit two ways of understanding of competitiveness in healthcare sector: in the era of aging population, matching the local demands contributes to develop healthcare market and enhance competitiveness; promoting inbound and outbound businesses contributes to the development of new market and business opportunities. Therefore, this section examines alternative options and scenar-

[22] For example, see http://www.y-hukushijigyo.or.jp/job.html (printed in Japanese, Accessed on 21 August 2012).

ios in order to match the local demands and to promote inbound and outbound market.

Figure 6. Comparison of retention by industry, and the number of workforce (2010)



Source: Ministry of Health, Labour and Welfare (2010a).

Options and scenarios to match the local demands

As this paper reiterated, Japan enters aging population rapidly and 5 millions of people are now authorized as long-term care holders. Japan has to supply workforce to match such staff demands. The MHLW, which is in charge of human resource planning in this sector currently, must choose to mobilize only local workers or to invite foreign-born workers. If the MHLW adheres to the first option, it has to prove that its human resource plans secure to supply enough workers in order to meet international standards. The MHLW emphasizes that inviting immigrant workers is an *easygoing* action[23] (emphasis added by author) and that immigrant workers distort labour market, especially wage system. However, as section 3-3 has exhibited, working conditions in healthcare sector is lower than other industries and the number of early-retirement is large. It is urgent for the MHLW to improve working conditions, especially working time and wage, in order to increase re-employment of re-signed practitioners and to decrease early-retirements.

If the MHLW changes its position and takes the second option, it must examine the introduction of mutual recognition of qualifications and language supports. Contrary to the MHLW's anxiety, qualification and language usually

[23] http://www.mhlw.go.jp/bunya/koyou/gaikokujin18/index.html (Accessed 27/2/2012)

constitute the barrier to inflow of immigrant workers. Even English-speaking country like the UK succeeds to control the number of immigrant healthcare practitioners from India and Philippines by verifying the levels of qualification and language (Inoue, 2010-2011). Japanese language, which is not spoken popularly in the world, is a barrier for immigrant healthcare workers, in general. Therefore, language support is necessary, if Japan decides to invite immigrant workers[24].

When Japan examines what a language support is ought to be, the EPA would be a good test case. Japan's EPA is bilateral agreement and it has a quota. With such features, inviting foreign-born practitioners under the EPA arrangement does not lead to influx of immigrants. The MHLW might be afraid of distorting national labour/working environment, but "Equal Pay" requirement would secure the local working environment, especially wages. Some ministries have started to improve language support to EPA candidates. The Cabinet Office and the MOFA came to concern the number of successful candidates of national examination: only 14% of the candidates of nurses from Indonesia could pass the national examination, even if they are qualified in their home country and they have practiced in Japan. The government decided to print *Kana* readings beside Chinese characters (*Kanji*) in the examination questions. Additionally, they made a *diplomatic* decision that allows the EPA candidates to stay one more year, so that candidates can be prepared for improved examination[25]. In contrast to the Cabinet Office and the MOFA, the MHLW responded passively to their decision, and announced a guideline that allows candidates from Indonesia to practice one more years in order to be prepared for national examination. The guideline symbolized the MHLW's attitude, as it did not automatically allow the candidates who meet the conditions for additional stay. It required preparing *written forms* that assured both candidates' diligence for the next examination and improved teaching programs prepared by host hospitals/clinics. After the policy changes by the Cabinet Office and MOFA, the number of success has increased in 2012. The experience in care subsector also gives Japan some implications for support to foreign-born workers. Language and vocational supports may contribute to the employment of foreign-born people in Japan, and also contribute to decrease of the costs for public assistance (livelihood protection) by local governments.

[24] 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.

[25] Candidates who scored higher ranks (to the 81st candidates, included successful applicants) were allowed to stay. www.mhlw.go.jp/bunya/koyou/other21/dl/o21_1-4-5.pdf (Accessed on February 27, 2012)

Options and scenarios to promote inbound and outbound businesses

Inbound and outbound businesses cover a wide range of businesses, such as research and development, medical technology, medical devices, pharmaceutical manufacture, nursing-care products, and so on. Unlike physicians, nurses, and care workers, most of these businesses do not provide direct service to local patients. Every labour in these businesses is neither necessary to be fluent in Japanese nor necessary to be qualified by national examinations, as far as he/she does not contact with local patients/customers. For these businesses, language barrier is an obstacle to competitiveness, because they lose possible customers (market) and skilled staffs. Therefore, ministries step forward to stimulate inbound businesses: they deregulated Japan's visa policy to invite foreign patients and their families, and they attempts to bring up medical translators and advisors (concierges) in cooperation with universities and schools.

When enterprises, hospitals and institutions develop their businesses in overseas markets, they need to increase the number of local employment. Local employees are desirable to be familiar with not only their home countries but also information on Japanese enterprises, hospitals, institutions, products and services. As far as they are locally employed, their fluency in Japanese is not necessary. Rather, it is essential for Japan to invite foreign-born workers (in many cases, students) in order to bring up such locally employed staffs. Currently, Japan's visa policy is favourable for highly skilled immigrants and students, and individual efforts, especially human exchange programs and technical cooperation, are developing. Close cooperation between ministries as well as stakeholders (including universities and enterprises) for introducing systematic efforts are expected, in order to enhance Japan's competitiveness in international markets.

Concluding remarks

Japan enters an era of aging population faster than any 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 labour market leads to not only match the staff demands but also leads to the growth of the healthcare-related market. In terms of inbound and outbound businesses, especially, Japan's experiences as a forerunner of aging population would strengthen Japan's competitiveness in this sector.

However, Japan is faced with many problems so far. Japan fails to mobilize local practitioners, and staff demands are not matched. Low wage and hard works 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, have requested that government should invite immigrant/foreign-born workers. The MHLW, which is responsible for human resource planning, must achieve satisfactory results of supplying enough local

workforces, if it denies accepting immigrant workers. Development of inbound and outbound businesses is inevitable, if Japan wants to be competitive in healthcare-related industries such as medical devices, foods, pharmaceutical manufacture, and nursing-care products.

Japanese language will constitute a barrier for immigrants, and it will take much time to attract immigrants than other English-speaking countries. Japan is strongly recommended to make early, close and realistic examinations of accepting foreign-born workers as fast as possible. 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 efforts by other non-English speaking countries would bring us many insights, when Japan officially decides to mobilizing foreign-born residents or inviting immigrants.

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