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The Japan-Philippines and Japan-Indonesia Economic Partnerships:

Healthcare Migration Scheme, The Negative Chain Reactions

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The Japanese economy has long been suffering due in part to an aging population. Needless to say, population decline and population aging have caused a rapid demographic change in Japan. To compensate for the past decade or so, Japan has started to actively intake foreign workers; although problems with Covid-19 slowed this process, Japan is beginning to see a gradual uptick in this activity, which the pandemic had put on pause, causing unexpected outcomes. Therefore, this argument will focus on pre-Covid days (right before 2020).

According to Japan's government data from April 2019, the number of resident foreigners hit a record high of 2.22 million, which is 1.76 percent of Japan's population (Ebuchi et al, 2019). Japan's economic strain has been evident for a while and is most visible in the labor market, particularly in the health care sector. Even though the number of elderlies in need of nursing and caregiving is increasing, the number of young people who wish to enter the health profession has been quickly declining. Consequently, Japan, "only recently, i.e., from 2006 onwards, has jumped onto the bandwagon of systematically recruiting health-caregivers on the global labor market" (Vogt 2018, pg2). Ironically, many Southeast Asian countries, from which Japan has been aggressively recruiting health professionals, are experiencing high demand, themselves, for well-trained and dedicated nurses and caregivers who are moving outwards to the international arena where the medical professions offer better financial stability.

Motivated by this migration stream, to fill in the gap in the health care labor

force, Japan established a labor migration scheme for these nurses and caregivers from Southeast Asian nations, predominantly from the Philippines and Indonesia. In fact, Japan signed an Economic Partnership Agreement (EPA) with the Philippines (JPEPA) and Indonesia (JIEPA), which allows large inflows of nurses and caregivers from each nation. Even though Japan did form this internationally cooperative approach between these nations to cope with its own domestic issue, which appears positive from an international relation's perspective (i.e., promotion of globalization), Japan seems reluctant and ill-prepared for the domestic implementation of this specific migration policy, which uncovers core sociological issues in Japan including xenophobia and lack of legal protection for minorities due in part to Japan being a homogenous nation. Many issues have arisen since these EPAs came into effect, and this has been problematic and controversial over the years in many ways. Issues include Japan's restrictive scheme for these migrant health care professionals, inadequate language training, and human rights violations, often resulting in migrants having to return to their respective countries too soon after they arrive. These factors clearly show the failure of this newly formed skilled migrant exchange policy. Not only would this mean the money and time spent on these programs would go to waste and the EPAs would remain unsuccessful, it could also worsen the image of Japan as a developed country and possibly derail future economic partnerships.

This study contributes to the existing literature on Japanese sociology by integrating empirical data and broader theories from international relations, economic policy, and social issues in Japan. My analysis of the issues with JPEPA and JIEPA suggests that the government should consider the implementation of policies that will make EPAs more functional, thus minimizing negative images of Japan. In the conclusion, it also takes into account the new challenges to these EPAs that have emerged due to the pandemic, addressing how even after the pandemic comes to an end, with all the preexisting issues, the health care workers may prefer to not stay and work in Japan.

As noted earlier, Japan has been facing severe economic demands from an aging society. Japan opened its doors to foreign care workers through trade negotiations instead of through labor policy: the JPEPA was negotiated in 2004 and signed in 2006, which included the plan of taking in 400 nurses and 600 caregivers into Japan within the first two years. The JIEPA was signed in 2007 which planned to

intake 200 nurses and 300 care workers per year for two years (Ford et al. 2013, 431). Between the years 2008 and 2011, a total of 1,360 Filipino and Indonesian candidates for registered nurse or certified caregivers entered Japan (Ohno 2012, 541-542). In the beginning, the Indonesian government was relatively optimistic because Japan's quota for Indonesian nurses and caregivers needed in Japan was much larger than in other developed countries. Philippine government officials initially expressed dissatisfaction over Japan's limited requests for Filipino nurses and care workers, but they were also relatively optimistic about this newly formed potentially beneficial relationship (Ohno 2012, 560). Although Japan opened its doors and a number of improvements have been made since the introduction of the schemes, its restrictiveness for these migrant health care professionals has been an issue for all countries represented.

As many other developed nations lower their healthcare worker immigration barriers to compensate for their shortages, "Japan has remained cautious, selective, and restrictive, despite rapidly growing health needs and increasing lack of healthcare worker capacity" (Yagi 2014, 244). With regard to maintaining a more stable tax base and employment in the healthcare sector, one would think it more advantageous of Japan to take a more active approach in the easing of trivial restrictions, thus providing smoother transitions for these migrant health professionals. Nevertheless, nursing and caregiver candidates who seek to enter the labor market in Japan must go through extensive schooling and work experience with minimal Japanese language and culture lessons before departing to Japan. The language preparation under the earlier policy implementation had been proven to be inadequate for those who migrated in 2008, so the language and culture training before departure was extended. Those who arrived in 2013 were required to complete a full year of study preparation: six months prior to their arrival and then six months after their arrival. After the arrival and completion of language and culture training, nurse candidates must undertake up to three years of employment and up to four years for caregivers. While being employed, candidates are required to continue studying Japanese while preparing for the respective national examination to become fully qualified professionals (Ford et al. 2013, 432). Contrary to nurse candidates who get to take the exam after the language and culture training, caregiver candidates are required to work for more than three years at their host institutions before taking the national exam. This has evidently made Japan less attractive to the migrating healthcare

workers especially considering that other nations offer equal or better pay and decent working conditions, which contradicts the purpose of these bilateral agreements.

Moreover, another aspect that concerns the Filipino and Indonesian governments is the fact that these candidates are considered "trainees" until they pass the Japanese national exam. This became a concern for these governments because they believed that these career nurses and caregivers would be dissatisfied with such demeaning arrangements which discredit the degrees and qualifications they acquired back home (Stott, 2008). Japan demands Filipino candidates to obtain a nurse license in the Philippines and have three or more years of nursing experience at a legitimate institution before accepting them. For caregivers, coursework from Probationer or Vocational School is required, which takes two years. On the other hand, Indonesian nurse candidates are required to attain nurse licenses in Indonesia and have two or more years of experience as a professional nurse, which is one year less than in the Philippines. Furthermore, Indonesian caregiver candidates, ". . . are required to graduate from a three-year nursing vocational school or a four-year college, or graduate from the same-year vocational school or college in any major plus obtain a caregiver certificate accredited by the Indonesian government" (Ohno 2012, 544-545).

Even with all of these qualifications, Filipino and Indonesian health professionals are not recognized as certified professionals until they pass the Japanese national exams, and they are not permitted to conduct professional duties that they were already performing in their respective countries. "This often-indefinite delay in licensure leads to "brain waste" where healthcare workers are overqualified to perform assigned tasks" (Yagi et al. 2014, 246). This also indicates suspicion, on the part of the Japanese people, concerning the skills and knowledge foreigners are acquiring in their respective countries, which could be regarded as insulting. The candidates accepted in Japan under JPEPA and JIEPA are already limited, and the requirements for these healthcare workers to work as qualified professionals are demanding: "Both governments [Philippines and Indonesia] anticipated larger demands and lighter requirements for their overseas workers in the most aged society in the world," which shows how their expectations have not been met (Ohno 2012, 544). This would naturally shift these governments' attention towards seeking a more effective economic partnerships with other countries.

As mentioned above, the very little language training became an issue for these

healthcare candidates. With the language training conducted under the scheme, the training remains insufficient compared to the extremely demanding Japanese national exam they must pass, which include exams that are practically identical to the ones designed for Japanese nationals. The exams these candidates must take to become qualified nurses or caregivers are all in Japanese language and include many technical terms, making it considerably more difficult for foreigners. According to Nikkei Asian Review (2018), only 20% of 2,800 who were accepted as candidates in 2016 under the EPA framework were able to earn their certification. Moreover, according to the Ministry of Health, Labor, and Wealth, "while the average overall pass rate for the nursing board exam is around 90 percent, the rate for EPA nurses was only 11.3% (47 passed out of 415) in fiscal year 2011 and 9.6% (30 passed out of 311) in fiscal year 2012" (Shima 2014, 3).

If the candidates successfully pass the exam, permanent residency can be negotiated; however, if they fail, they have to return to their respective countries. With such high stakes associated with the national exams, not only do nurses and caregivers have to focus on exam preparation, but the host institutions also have to give extensive assistance for the preparation. "Fitting the exam to the needs of the workplace, while still taking on staff including foreigners, is another issue for the field" (*Nikkei Asian Review*, 2018) This may distract the candidates from actually learning the practical terminologies and professional skills needed for work at medical institutions, which seem mutually unbeneficial for both the candidates and the host institutions. Moreover, both Filipino and Indonesian government officials and businessmen involved in the EPA negotiations had strong expectations because they were expecting their candidates to bring back advanced healthcare education and practices to their countries for further advancement in their own health industries (Ohno 2012, 559). This expectation cannot possibly be met if their healthcare professionals are not focused on acquiring practical professional skills at their host medical institutions in Japan because they're desperate to pass the exams to stay. If their own health industries aren't advancing as they have expected, it is likely that these partnering countries will develop a negative image towards the ineffective process caused by the unrealistic expectations of the Japan side.

Yogi et al. (2014) state that the lack of sufficient economic support to provide practical training and learning tools for candidates is also one of the many challenges that inhibit successful implementation (245). "After only two Indonesian candidates

and one Filipino candidate passed the nursing exam in 2010, the media focused on the extremely low passing rate (1.2%) among Indonesian and Filipino examinees compared with the high passing rate (89.9%) among Japanese examinees, and criticized Japan's "unrealistic" policy even more severely" (Ohno 2012, 550). With so many candidates having to return home after failing the exam, it became clearer that the one-year language training for foreign candidates under the scheme of EPA was not sufficient for many healthcare migrants. Hokkaido University's Associate Professor Otomo, who has been exploring the intersection between language, migration and labor policies, refers to the large number of unsuccessful candidates as a "disappointing" outcome, further claiming that some researchers believe that the program itself is 'designed' to fail (Gunawan, 2020). This indicates the counteractive nature of the implementation compared to what these nations are trying to achieve with the EPA. Naturally, these impossible standards can set a negative precedent suggesting that these healthcare professionals are not fully welcome, thus showing Japan's counteractive intentions and thus worsening their own image regarding immigrant relations.

Kawaguchi et al. (2012) claim that passing the national exam may include not only language problems but also differences in the education curriculum and policies between Japan and respective homelands (650). Since Japanese residents have high expectations for Japanese language fluency for those they associate with in healthcare settings, the language barrier and foreign environment can be challenging to Filipino and Indonesian candidates. Japan did succeed in introducing a new policy to intake more foreign skilled workers into Japan, but "this acceptance also gives rise to ethical questions of integrating foreign workers into the society" (Susai 2011, 1). The fact that Japan remains racially and culturally homogenous has made Japan enforce policies that limit the entrance of foreign workers into the country, and this has made it difficult for healthcare professionals to assimilate into Japan. "The conflation of national security with ethnic and cultural homogeneity undermines liberal democracy in Japan" (Hollifield and Sharpe 2017, 385).

Needless to say, managing substantial everyday tasks including studying Japanese language, preparing for the national exam, and working as full-time trainees under Japanese nurses or care workers in a foreign land creates a stress-inducing environment: these candidates also have to overcome the uncomfortable feeling and mental distresses induced by insufficient Japanese language ability,

among many other hardships (Ohno 2012, 562). In 2017, the Japanese government did expand the framework of the vocational training program for foreign workers to compensate healthcare services. Nevertheless, the training program managed by Japanese firms, which accept these healthcare trainees, has been criticized because of its exploitation of cheap labor which they are acquiring from these developing nations— "many cases have been reported of trainees subjected to illegally long work hours and denied proper wages" (The Japan Times, 2017). With the existing stresses these healthcare workers have to endure, this sort of abuse perpetuated by their employers must be terribly strenuous. According to Hirano (2019), 16%–38% of the healthcare professionals who actually passed the national board examination have chosen to leave Japan, many of them claiming that working conditions and long hours made it "impossible to balance work and family or proved injurious to their health."

At the end of 2016, there were 229,000 trainees under the program, and it included 23,000 Filipinos and 19,000 Indonesians. According to the Labor Ministry, there were 4,004 employers in the program that violated labor laws in 2016 (many starting from 2003): violations included 24% of work hour regulations, 19% of failure of safety regulations, and 14% of unpaid overtime, along with countless reports of workplace abuse and bullying and inability to get compensation for work-related injuries and illnesses (The Japan Times, 2017). Not only that, the Japanese government actually refused to guarantee minimum wage levels, but did agree to "request" that employers meet the figures that each government asks for (i.e., the Indonesian government decided that the monthly salary for a nurse trainee should be around 200,000 yen and 175,000 yen for care workers) (Stott, 2008). The lack of protection and surveillance for these healthcare professionals does not make Japan an ideal host nation for many candidates that come from the Philippines or Indonesia. Japan must provide a more attractive work environment that includes benefits such as higher wages and human rights protection to keep attracting foreign healthcare workers. The systematic hardships and the labor migration failure these healthcare workers would have to endure will only spread negative social images of Japan abroad. With such hostile work environments in Japan, it will be challenging for the Filipino and Indonesian governments to promote this scheme under the EPA, to encourage healthcare professionals to choose Japan instead of other host nations.

As mentioned in the beginning, due to the extraordinary circumstances such

as the pandemic, for argument's sake, this article has focused on pre-Covid days (right before 2020). The JPEPA and JIEPA were built around the premise of gaining mutual benefits for both migrant-sending nations and receiving nations, which would improve the economic and employment benefits within this skilled migration field. However, considering the challenges Filipino and Indonesian healthcare candidates have faced, including the restrictive scheme to enter the Japanese labor market, inefficient language training with the low rate of examination passage, and human rights violations, it is clear that the fundamental structure of the EPA programs requires further evaluation. Additionally, even if the candidates do pass the exam and decide to stay, they will face limitations in their career choice—i.e., Japan-certified elder caregivers are not allowed to work as nurses even if they possess a nursing license from their own countries (vise-versa), and these certified professionals can only work at medical institutions that accept EPA program laborers (Gunawan, 2020).

Although the Covid-19 pandemic has naturally caused further issues and delays in this scheme over the past few years, technical adjustments have been made, and Japan has welcomed a few hundred health care professionals starting from 2021. For example, the 14th batch of Filipino nurse and care worker candidates, who underwent online language training, arrived in Japan in July 2022 to begin their employment in hospitals and caregiving institutions. Before these candidates start work with their respective employers, they will go through another 6 months of intensive Japanese language training (*Ministry of Foreign Affairs of Japan*, 2022). The reboot of these programs seems optimistic considering these hard times: however, once this so-called "mutually-beneficial" exchange is again starting to function reasonably successfully, it is obvious that further negotiations are needed to meet all needs.

Additionally, due to the status of an aging population and/or shortage in the healthcare sectors in other developed nations, the Philippines and Indonesia have been actively sending their healthcare workers to other nations such as Canada, the US, and the UK, etc., which means securing quality caregivers and nurses for Japan is that much more competitive. Matsuno (2009) states, "since the recruitment efforts from the Western countries act as a strong pull factor, those nurses who migrate first within Asian countries tend to continue migrating to those countries such as the U.S. and the U.K." (23). According to a survey conducted by the Ministry of

Foreign Affairs of Japan (2022), in 2014, when Indonesians and Philippines were asked which countries/ organizations were the most reliable friend to your country (11 countries including Japan, US, China, Germany, etc.), 47% of Indonesians chose Japan while 31% of Filipinos chose Japan. However, in a 2021 survey, when they were asked the same question (this time with 22 countries in question including Japan, US, China, Germany, etc.), only 18% of Indonesians and 21% of Filipinos chose Japan. This strongly indicates that the image of Japan has declined over the years, and/or other countries are becoming more desirable.

It is crucial for Japan to lower its immigration barriers, provide extensive language training, and improve the work environment for these healthcare professionals to sustain Japan's image as part of the globalized world. By worsening the image of Japan among these countries, it will be even more difficult for Japan, in their future recruitment efforts, to attract essential workers such as caregivers and nurses. If Japan does not immediately tackle unfair treatment and limited career opportunities, as well as restructuring its language testing requirements, the best healthcare candidates may decide not to work in Japan even after the pandemic comes to an end. This would mean that all the money and time spent on each candidate would go to waste and the EPAs will remain ineffective, possibly worsening the image of Japan as a developed country and thus putting a strain on future economic partnerships.

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