Human Resources for the Health and Long-term Care of Older Persons in Asia

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Human Resources for the Health and Long-Term Care of Older Persons in Asia

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FOREWORD

Nurses are indispensable. They can be seen in any healthcare facility even when doctors are not present. In communities, nurses are at the front line of healthcare. They contribute greatly to improving it – from public health to cutting-edge medical treatment.

Care workers appeared more recently but they are essential. In most Association of Southeast Asian Nations (ASEAN) Member States (AMS), many people preserve the beautiful tradition of families and relatives caring for older people. In an ageing society such as Japan, however, where about a third of the population is aged 60 or more, who can care for older people? Most family caregivers are women. Does the tradition of family care not hinder their social participation or empowerment? As a population ages, professional care workers become more important.

AMS and East Asian countries will see rapidly increasing numbers of older people in the coming decades. Demand for nurses and care workers is expected to surge. Some countries will have a serious shortage of nurses and care workers, while some, where fertility rates are high, will be able to send them to other countries. Cross-border movement of such healthcare workers will be accelerated by regionally uneven population ageing.

Nurses and care workers need to have a close relationship with their clients. Such workers' service skills, including communication and language, are directly linked to clients' physical and mental health outcomes. Nurses and care workers require intensive training before moving to other countries to optimise their capacities.

This book focuses on Indonesia, Japan, Malaysia, the Philippines, and Thailand. Indonesia and the Philippines represent countries sending nurses and care workers abroad, while Japan and Malaysia are examples of destination countries. Thailand is one of the fastest-ageing AMS. Every chapter reveals each country's unique policies and systems for healthcare human resources and problems in securing them. Although each chapter focuses on a specific topic rather than a comprehensive discussion, I hope that readers can understand the diversity of the issues related to healthcare

human resources and that the book's findings will promote further research and discussion.

As a Japanese national, I have a keen interest in care workers coming to Japan, which has the highest proportion of older people in the world. Cross-border care workers are critically important to sustain the long-term care system as the younger generations shrink. Japan's policy on allowing care workers into the country was conservative until the late 2000s, but in response to the serious shortage of its domestic labour force for care workers, Japan has opened several new pathways to legally accept foreign care workers since 2017. Readers can 'hear' the voices of cross-border care workers in Japan in chapter 1, which focuses on one such a pathway. Care workers came to Japan not only for economic reasons but also to improve their skills and learn care technology and to learn about Japan's culture. About half said they simply like caring for older people. We need to understand the diversity of cross-border workers' wishes and hopes. I greatly appreciate their substantial contribution to Japan's long-term care system, and I believe they will disseminate their knowledge and skills, helping develop long-term care in their home countries and the region, where populations are starting to age rapidly.

ASEAN agreements and documents encourage skills mobility. The Economic Research Institute for ASEAN and East Asia (ERIA) argued in its ASEAN Vision 2040, published in 2019, that because skills mobility provides a competitive edge, it is essential to the region's rapid economic growth. To deepen regional cooperation and integration, ASEAN has expedited mutual recognition arrangements (MRAs) for professionals. AMS signed the MRA on nursing services in 2006. It does not automatically recognise nursing certification in all AMS; bilateral agreements are required to assure quality and recognise qualifications. Reaching bilateral agreements is not straightforward and this book explains the implications of developing regional policies on cross-border nurses and care workers. I hope the study will be a driving force that will promote skills mobility to build competitive and knowledge-based economies.

Most cross-border nurses and care workers are young. I hope continuing research and policies related to cross-border healthcare professionals will support and protect the young people who bravely work abroad after hard and intensive pre-migration training.

Last but not least, I express my greatest appreciation for the tremendous support of everyone involved with this project, from the authors to the nurses and care workers who participated in the study. Dr Yuko Tsujita of the Institute of Developing Economies, Japan External Trade Organization (IDE–JETRO), the study's principal investigator, showed outstanding leadership and guided the study to success. Her effort and achievements deserve applause. The study strengthened more than a decade of collaboration between ERIA and IDE–JETRO and offers an excellent opportunity to deepen it and contribute to economic development, narrow the development gap, and promote sustainable development in AMS and East Asia.

Hidetoshi Nishimura
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Economic Research Institute of ASEAN and East Asia

FOREWORD

The coronavirus disease (COVID-19) pandemic has reaffirmed the vital role nurses play in healthcare and prevention. They risk their own health to sustain their country's health system. What has also become increasingly apparent is that many nurses in our communities, hospitals, and aged care facilities were born and trained overseas. When British Prime Minister Boris Johnson was discharged from hospital after being treated for COVID-19, he thanked the hospital staff for saving his life in a video he posted on Twitter on 12 April 2020: '... And I hope they won't mind if I mention in particular two nurses who stood by my bedside for 48 hours when things could have gone either way. They are Jenny from New Zealand... and Luis from Portugal....' In Japan, we have increasingly witnessed nurses and particularly care workers who were trained abroad.

In Japan, modern nursing education began in the late 1880s. Nurses have struggled to improve their professional status by introducing various requirements, including nursing degree courses and a licensing system. Like early nursing work, care work for the elderly has low status and is poorly paid. Attempts have been made to ensure that certified care workers and certified social workers involved in elderly care have licences. Some care workers receive a qualification allowance reward for their credentials. Care workers, however, still receive lower wages than the average worker and their service duration is shorter than that of other workers. Caring for the elderly still faces difficulties associated with low wages and a limited supply of care workers.

According to the latest statistics from the United Nations, 28.4% of the population in Japan is 65 years of age and older. Japan has the highest proportion of elderly people in the world. Other Asian countries also have increasingly ageing populations and, thus, increasing demand for elderly care. In many parts of Asia, families are important in caring for the elderly. Demographic, economic, and social transformation, however, push many families to hire migrant nurses as care workers. While some elderly are looked after by their families or care workers at home, others are cared for at facilities for the elderly. Some are sent back and forth between home, hospital, and facility. Caring for the elderly is often regarded as a 3D job – dirty, dangerous, and demeaning – and is physically and emotionally demanding. An ageing population, shortage of local care workers, and dependence on migrant nurses and/or care workers often occur simultaneously.

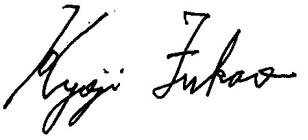
This book fills the gap in our knowledge of international migration of nurses and care workers by contributing the following:

First, it reveals the characteristics of nurse and care worker migration. Some theories can explain why migration occurs, including the wages offered by sending and receiving countries in the framework of neoclassical economics, push–pull factors such as wages, and opportunities for training and promotion, which determine migration in the framework of the dual labour market and migration as a family strategy posited by the theory of new economics of labour migration. While some nurses and care workers go abroad to help their families, others encounter considerable hurdles because their families oppose their working overseas. The international migration of nurses and care workers is distinctive in that family factors, particularly for married females, might involve the complicated interplay of choosing between family and career. Most nurses and care workers are female. Further analysis is recommended.

Second, the book shows multiple patterns of international mobility of nurses and care workers. Traditionally, international migrants move from one country to a another and then might move back and forth. Some nurses and care workers might view the destination country as a steppingstone to another country. Those who are licensed nurses in their country of origin but are care workers in the destination countries are disadvantaged by the gap between their credentials and the simpler tasks they perform. Care workers for the elderly are more invisible and more likely to be contracted informally than licensed nurses. Care workers are paid lower wages and more often work in inferior jobs than nurses and are, therefore, more motivated to re-migrate.

Third, policymaking in the receiving countries is important to attract, train, and retain migrant nurses and care workers. Some Asian countries have attempted to standardise training and licensing and guarantee minimum wages for care workers. The book illustrates how willingness to stay in a destination country might depend on what jobs care workers were recruited for. Willingness to stay for a long time varies amongst licensed nurses hired to do non-nursing work.

Human Resources for the Health and Long-term Care of Older Persons in Asia is the first collaborative work of the Institute of Developing Economies, Japan External Trade Organization (IDE-JETRO) and the healthcare unit of the Economic Research Institute for ASEAN and East Asia (ERIA), which includes Dr Osuke Komazawa, Mr Sota Machida, and Ms Nanda Sucitra Putri. We extend our heartfelt thanks to ERIA for its generous support. We believe that this volume will deepen our understanding of the training, employment, and international migration of nurses and care workers in East Asia and ASEAN, and facilitate further research in this field after the COVID-19 era.



Kyoji Fukao
President
Institute of Developing Economies (IDE–JETRO)

PREFACE

The international migration of nurses and care workers has increased in recent years. Some factors, such as the ageing population, the promotion of medical tourism, the growing demand for better-quality health services, the shift of family and home care to institutional care, and the turnover of local nurses, have contributed to greater demand for nurses and care workers. According to International Migration Outlook 2015, published by the Organisation for Economic Co-operation and Development (OECD), on average, 14.5% of nurses and 28.5% of home-based care workers in OECD countries were born abroad.

Several conditions ease recruiting foreign-trained or foreign-born nurses:

First, free or relatively open labour mobility is stipulated in some bilateral, multilateral, and regional trade agreements.

Second, mutual recognition agreements (MRAs) allow qualified nurses to practice in other countries. MRA parties, however, do not automatically recognise the qualifications of other parties' nurses, and the application of MRAs varies from one state to another. For example, the Trans-Tasman Mutual Recognition Act allows Australian nurses to work in New Zealand and vice versa. The Association of Southeast Asian Nations (ASEAN) MRA on nursing services, however, which came into force in December 2012, facilitates nurses' mobility to only a few countries.

Third, most receiving countries and regions require nurses to have suitable qualifications or licenses. Some licensing exams, such as the United States' National Council Licensure Examination, are used for qualification of migrant nurses in Asia.

Fourth, some bilateral and multilateral trade agreements include 'barter deals', under which nurse-sending countries provide privileges to their counterparts in trade regulations, and nurse-receiving countries open their labour markets and prioritise their counterparts. Japan, under bilateral economic partnership agreements with Indonesia, the Philippines, and Viet Nam, allows nurses and care workers from these countries to work for several years in Japan after acquiring a certain level of Japanese

language proficiency. If they pass the national licensing exam within the specified time (4 or 5 years), they can renew their work permits without limit. If they fail the exam, they cannot continue to work in Japan and must return to their home countries.

Asia is the main source of migrant nurses. In OECD countries, for example, 221,344 nurses are from the Philippines, 70,471 from India, 24,440 from China, and 11,431 from Viet Nam, according to International Migration Outlook 2015. The Gulf countries are also main recipients but the number of nurses by nationality is not available to us, so the total Asia-trained nurse workforce is likely underestimated. Less research has been done on nurses from the sending countries' perspective than on foreign-trained nurses in receiving countries.

The institutional and home care worker labour market is less regulated than the migrant nurse labour market. Some foreigners are engaged in long-term care at institutions and in homes through an informal contract arrangement or even without legal status. Domestic foreign workers might be engaged in care work as well. As some countries in Asia face rapid population ageing, it is important to illustrate the current situation and issues of and challenges for migrant care workers in Asia from sending and receiving countries' perspectives.

This report focuses on Japan, Malaysia, Indonesia, and Thailand.

Although this volume relies largely on results from short projects, they are based on questionnaire surveys or field observations, making this study a very valuable one as it collected real voices of migrant workers. Each chapter is a piece of a jigsaw puzzle depicting the mobility of nurses and care workers in Asia. We hope that future studies based on this report will complete this huge and intricate puzzle.

Yuko Tsujita

Bangkok

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Japan's *Kaigoryugaku* Scheme: Student Pathway for Care Workers from the Philippines and Other Asian Countries

Ma. Reinaruth D. Carlos and Yurika Suzuki

Abstract

While Japan has the highest percentage of elderly citizens in the world, its dependence on foreign care workers has been negligible compared to other countries facing a similar issue. In recent years, the country has implemented several foreign care worker schemes set to alleviate the worsening shortage. In this report, we focus on the student pathway for foreign care workers (*kaigoryugaku*) that is an offshoot of the addition of 'care work (*kaigo*)' in the visa categories in the Revised Immigration Law (2017). We describe the care work student scheme and its emerging trends in detail and explain the differences between the Economic Partnership Agreement (EPA) and Technical Intern Training Program (TITP) schemes, particularly in terms of regulation and the role of the public sector. We also discuss how private intermediaries or facilitators are involved and collaborate to recruit, train, and hire international students. In the final section, we summarise the discussion and make suggestions on how the government, both at the national and local levels, can complement the efforts of the private sector to make the scheme work to meet the current and future demands for labour in the care sector.

Keywords: international migration, care work students, Japan, foreign worker policy

1. Introduction

Addressing the severe shortage of workers who will look after the increasing ageing population has become one of the most pressing issues in many countries today. Japan is no exception. The country has the highest percentage of citizens aged 65 years and above, estimated at 28.1% of the total population as of August 2018 (Ministry of Internal Affairs and Communications Statistics Bureau website, 2018). Its dependence on foreign care workers has been negligible compared to other countries facing a similar issue. In recent years, however, the country has shown dramatic changes in its foreign worker policy. In the care work sector, it has introduced several schemes (or pathways) for foreigners to participate in the labour market. Indeed, the past two years have seen radical changes in policy related to foreign workers, particularly in the market for unskilled and semi-skilled workers.

In this chapter, we focus on the student pathway for foreign care workers (*kaigoryugaku*, referred to hereafter as the care work student scheme) that allows international students who finish a 2-year care work training course to convert their visa into 'care work', a new visa category created in the revision of the Immigration Law in 2017. After introducing the available pathways and describing the care work student scheme in detail, we look at the emerging trends in student enrolment/admission into Japanese language schools and care worker training (or vocational) institutions. We then discuss the roles of the national and local government units (LGUs) and show that unlike the national government-led Economic Partnership Agreement (EPA), the current care work student scheme is largely private-led. The information presented in this report is valid as of March 2019, and for the latest changes and revisions in the schemes, the reader is recommended to refer to the pertinent official websites.

In section 4, we highlight the roles of some Japanese stakeholders that facilitate recruitment, education/training, and employment, or the 'intermediaries'. In the final section, we summarise and make suggestions on how the government, both at the national and local levels, can complement the private sector's efforts to sustain the scheme and contribute in the alleviation of the shortage of care workers in the country.

The findings in this report are based on interviews and data gathered during fieldwork from May 2018 to February 2019.[1] The authors obtained ethical permission to conduct the study from Ryukoku University in April 2018.

1.1. Trends in foreign workers' policy and the labour market for care workers

a) Recent transformations in Japan's foreign workers' policy

Japan's labour shortage problem is not isolated to the care work sector. It is part of the larger problem covering the entire economy and, thus, must be understood within this context. The shrinking population, the ageing citizens, the 2020 Olympics, and a significant increase in the number of foreign tourists are all compounding and aggravating the country's labour shortage problem. In this section, we introduce the recent reforms in the immigration law and other related laws that are designed to alleviate the shortage in other sectors as well.

Three significant developments attest to the transformations in Japan's foreign worker policy. It must be noted, however, that the current administration does not see these as comprising an 'immigration policy', which is defined as a long-term migrant settlement programme (Komine, 2018). First, under the Abe administration, the 'alleviation of the labour shortage' was explicitly cited for the first time as the reason to take in foreign workers, especially in the 14 sectors in dire need of unskilled and semi-skilled labourers (Nikkei News Online, 2018).[2] Until recently, most of the foreigners who worked in Japan were de facto workers whose statuses of stay (visas) were based on two types – those in which the kind of job and period of stay were largely unrestricted (type 1), and those in which the type of job and the period of stay were highly restricted (type 2) (for details, see Komine (2018)). Examples of the first type (type 1) were foreigners whose status was on the merit of either having a spouse who is a Japanese national or parents or grandparents who have Japanese blood (Nikkeijin). The latter (type 2) included students, technical

[1] A part of this study was conducted in collaboration with the Ryukoku University Sociocultural Research Institute project (FY2018–2019) entitled 'International Migration of Nurses from Myanmar: Implications on the Domestic Labor Market, Health System and Japan as Destination'.
[2] The 14 industries are care work, building cleaning, farming, fishery, food and beverage production, food service (such as restaurants, cafes, and bars), material fabrication (such as metal casting), industrial machinery production, electronics and electric appliance related, construction, shipbuilding and marine equipment, automobile maintenance, aviation services, and lodging (hotels).

interns and trainees, and candidate workers under bilateral EPAs (see section 1.2 for the details of these programs). While these people actually worked and even became essential sources of unskilled or uncertified workers in many sectors, the government indicated that the aim for admitting them was not to alleviate the labour shortage, but for other purposes, such as study, technology transfer, and international cooperation.

In the past 10 years, there have been diversification and reforms of the foreign worker labour recruitment schemes (highly skilled professionals, students, technical trainees, and government-to-government agreements). In 2012, a programme for highly skilled foreign professionals (*kodojinzai*) was launched. Under this scheme, applicants are screened using a point system based on educational and work qualifications, age, salary, and bonus points on individual achievements, such as Japanese language proficiency, the number of patents owned, and the university of graduation.

The government has also introduced reforms in the Technical Intern Training Program in care work. For example, more measures are being put in place to improve the working conditions of the trainees, protect their rights, and provide pathways to career development and permanent residency. Care work is now included in the list of sectors that can accept technical trainees. The government is also exploring other source countries that can provide skilled, unskilled, or semi-skilled workers under bilateral memoranda of cooperation, like for example, with India[3] and Myanmar[4].

Lastly, in the past, Japan's labour policies (both towards *de jure* and type 2 *de facto* foreign workers) did not make provisions to encourage long-term stay in Japan.[5] However, the Abe administration has been exerting efforts to provide a more accessible pathway for permanent residency in Japan for 'qualified' foreign workers. Rules regarding the duration of the visas and their extension have been relaxed for some categories. For example, previously, technical trainees were allowed only three years of stay, after which

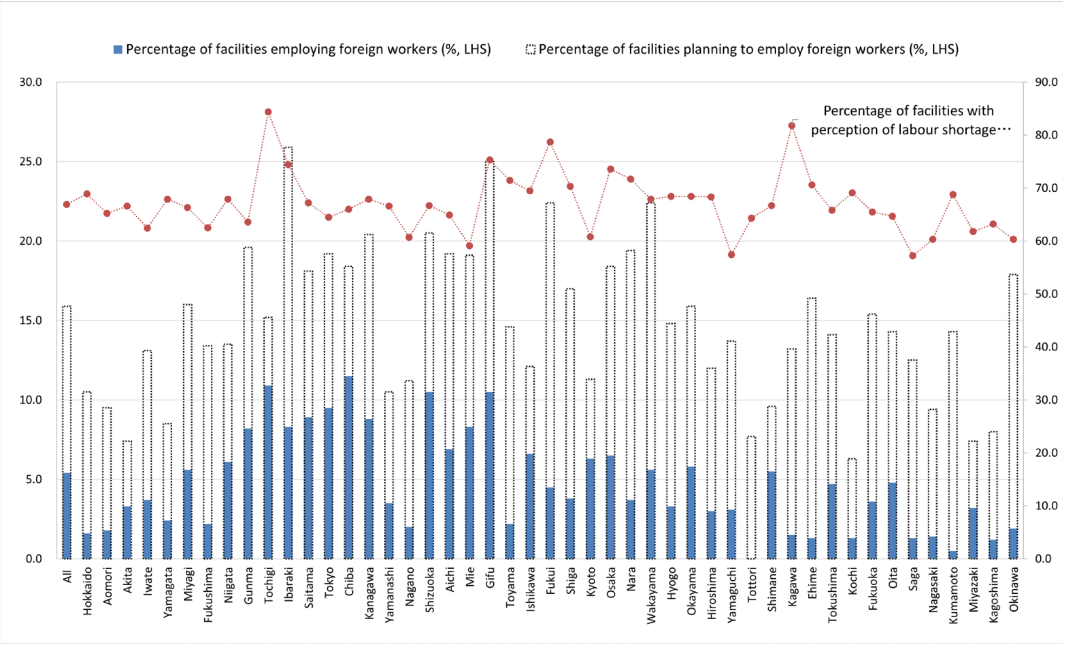
[3] India sends technical interns under the 'Memorandum of Cooperation between the Office of Healthcare Policy, Cabinet Secretariat, Government of Japan, The Ministry of Health, Labour and Welfare of Japan and the Ministry of Health and Family Welfare of the Republic of India in the field of Healthcare and Wellness', which was signed on 29 October 2018. https://www.kantei.go.jp/jp/singi/kenkouiryou/pdf/h301029_india_hc.pdf (accessed 30 September 2019).
[4] The Japanese government concluded a memorandum of cooperation on specified skilled workers with the government of Myanmar on 28 March 2019. https://www.jitco.or.jp/en/news/article/592/ (accessed 30 September 2019).
[5] The immigration law required 10 consecutive years of residence in Japan, five of which as a worker, to be able to apply for permanent residency, except in exceptionally meritorious cases or in the case of being a spouse or dependent of a Japanese national.

they had to return to transfer the technology learned in Japan to their home countries. Now, they are allowed to stay longer provided they meet the requirements regarding their skills and language proficiencies. These changes are a deviation from the country's policy trend of hiring foreign workers on a mainly temporarily basis. Indeed, given the current demographic and economic circumstances, Japan's alternatives in solving the labour shortage problem have narrowed such that relaxing rules to encourage and retain foreign labour migration has become inevitable.

b) Current trends in the labour market for care workers

As mentioned above, the severe labour shortage is the primary reason for further opening of the care work labour market to foreigners. In Japan, an index comparing the number of jobs available to the number of workers seeking jobs, or the effective job offer to job seeker ratio, is used to measure the severity of the labour shortage. A value exceeding 1 suggests a labour shortage, while a higher value means a more severe shortage. The ratio for all sectors in the third quarter of 2018 stood at 1.63 (163 job offers per 100 job seekers). However, the rate for the long-term care sector (only for jobs in facilities, excluding homecare) was much higher, at 3.69 in the same quarter of 2018 (Japan National Council of Social Welfare, 2019. In a nationwide survey conducted in 2017 of 8,782 long-term care facilities by the Care Work Foundation (2018) regarding workers' perception of a labour shortage, 66.9% gave a positive reply (see Figure 1.1). The opinion appeared to be strongest amongst facilities in Tochigi and Kagawa prefectures (at more than 80% of all facilities), but further studies are necessary to determine whether the shortage is felt more in rural (or less-populated areas) rather than urban areas (or more-populated areas). In some cases, especially in rural areas, the shortage in the workforce resulted in the closing down of facilities. To resolve the issue, employers have intensified their efforts to attract students, former local residents, and other potential entrants in the labour market, but the market has not shown a remarkable response.

Figure 1.1: Percentage Share of Facilities with a Perception of Labour Shortage and Employing/planning to Employ Foreign Workers by Prefecture (2017)



LHS = left-hand scale, RHS = right-hand scale.
Note: n = 8,707.
Source: Compiled by the authors from survey data conducted by Care Work Foundation (2018).

The severe shortage is expected to worsen by 2025, when the baby boomers born in the 1950s will reach the age of 75 years old (which is termed as the '*2025nen mondai*' in Japan). By this time, the ratio of those aged over 75 years old (the old-old group) is expected to reach its peak. Moreover, one out of five seniors (65 years old and above) may have dementia. Both groups will need more intensive, more specialised, and more frequent long-term care services. The task, therefore, is to address not only the current shortage but also the demands of the market in the medium-term and beyond 2025.

On the other hand, despite reports and data reflecting the severity of the labour shortage and the government's efforts to solve it, there are considerable variations in the facilities' attitudes towards employing foreigners. Figure 1.1 shows the low percentage of facilities that are already employing foreigners. For all of Japan, only about 5.4% (national average) were employing foreign care workers in 2017, with only Chiba, Tochigi, Shizuoka and Gifu prefectures registering more than 10%. There are also wide variations in terms of the percentage share of facilities that have plans to employ foreigners. At the top is Ibaragi, in which 25.9% of facilities within the prefecture expressed their intention to employ foreign

care workers, as opposed to 15.9% of all facilities across the country (Figure 1.1). We can partly attribute the low rate to their hesitation due to a lack of experience dealing with foreign workers and perceived difficulties in communication and in dealing with cultural differences. These restrictive labour policies, as well as these seemingly passive attitudes of long-term care facilities, brought about the minimal number of foreigners working in the long-term care sector and the low dependence on foreigners to fill the shortage. There are no official data on the number of foreign care workers, but Kakuta (2017) estimated that there are only a total of 3,500 foreigners in this sector, with 42% of them born in the Philippines.

1.2. Pathways for foreign care workers

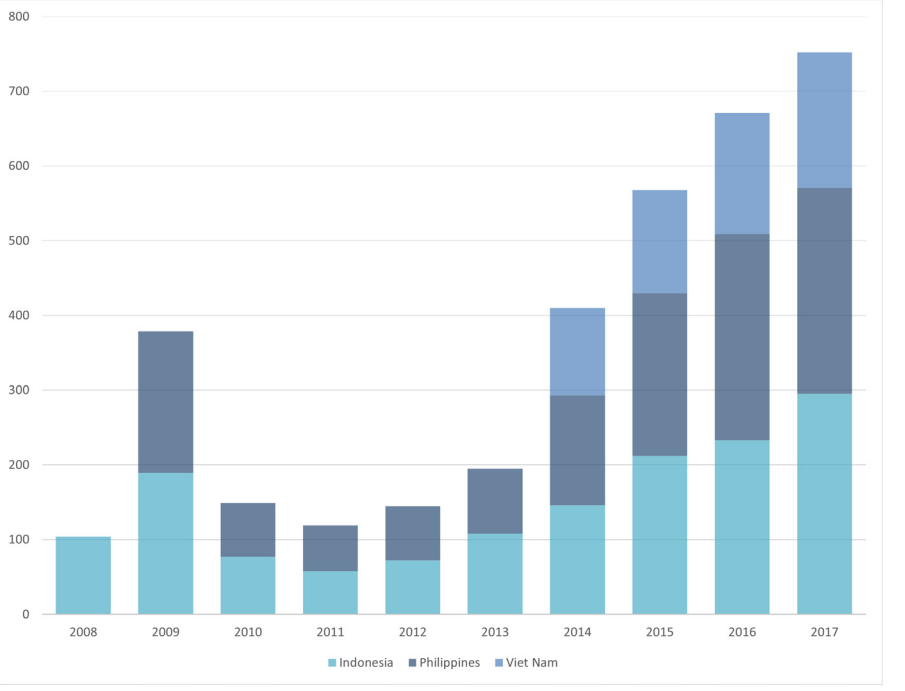
At the policy level, the administration has been trying to introduce and improve the paths in which foreigners can participate in the care workers' labour market. They can be categorised based on their status of stay. Until the mid-2000s, foreign care workers comprised permanent and long-term residents who held residence statuses that did not have restrictions on the type of activities or number of hours they were allowed to work. Especially for Filipino women who came to work in the country in the 1980s and 1990s and are now married to Japanese, care work has become not only a source of living but also provides a sense of self-worth and belongingness in the Japanese society (for details, see, for example, Carlos (2005; 2010).

Meanwhile, in 2008, the first batch of certified care worker candidates from Indonesia arrived under a bilateral agreement (EPA). They are considered 'candidates' because they do not possess a Japanese national license for care workers. Initially, the candidates obtain the visa for 'specific activities' which is valid for four years. During this period, they work in a long-term care facility while preparing for the licensure examination. They can take it only after completing a 3-year training as a care worker in Japan. Passing it will entitle them to work as a full-time certified care worker, but if they fail after their second attempt, they have to return to their home country. Aside from Indonesia, the Philippines (since 2009) and Viet Nam (since 2014) also deploy its graduates of nursing or caregiver courses under the scheme.

The EPA programme for nurse and caregiver 'candidates' was officially designed to promote bilateral economic cooperation between Japan and the three countries mentioned above, but stakeholders of this programme seem to have the common

presumption or belief that the programme was developed to alleviate the labour shortage. Now in its tenth year, the scheme does not seem to contribute considerably in alleviating the shortage through the employment of foreign care workers. This is partly due to the setting of a quota of 300 people per year per sending country, which is small considering the growing labour demand. The major reason, especially during the first few years of the scheme's implementation, was the high cost and lack of manpower to manage the programme on the ground. The Japan International Corporation of Welfare Services (JICWELS) (2018) reported that until FY2017, a total of 3,529 candidate care workers arrived, and 781 are scheduled to arrive in FY2018. The detailed annual number of arrivals from 2008 to 2017, as shown in Figure 1.2, reveals a sudden and significant decline during the first half, then an increasing trend in the last five years of its implementation. The recovery was the result of amendments in the scheme around 2013–2014, such as, for example, strengthening the Japanese language training programme and increasing the amount and kinds of subsidies extended to the host facilities. JICWELS also periodically conducts hearings with the candidates and the facilities to identify and address problems on the ground.

Figure 1.2: Arrivals of Certified Care Worker Candidates under the EPA (FY2008–2017, per country)



Note: The fiscal year (FY) begins in April and ends in March of the following year. It also coincides with the academic year.
Source: Compiled by the authors from JICWELS website.

On the labour supply-side, while the scheme has been gaining more popularity amongst long-term care facilities, the number of foreign applicants has been on the decline every year, even sometimes less than the number of slots offered by long-term care facilities. For example, in the case of the Philippines, during the first matching in 2009, there were more than 5,000 applicants. However, for the 2018 matching (pairing), the number went down to 511. On the other hand, the number of offers from employers went up to 643 workers, and eventually there were only 288 successful matches in the same year (JICWELS, 2018).

High attrition and low retention rates are also a source of concern. As of March 2017, a cumulative total of only 506[6] passed the licensure examination (JICWELS, 2018). Out of those who passed, a considerable number had already quit their job, either to return to their home country or work in another destination. In fact, of the 355 who passed until January 2016, 105 have already left Japan (MHLW, 2017). Some who chose to work in other destinations expressed their concern about the long time they would need to wait to obtain permanent residency and to bring their families to Japan. Another issue was regarding the absence of a career path from certified care worker to registered nurse. Under the current system in Japan, the Filipino care workers who are nursing graduates in their home country do not qualify to take the nursing license examination in Japan.

One issue from the point of view of long-term care facilities is the list of strict requirements imposed on employers in terms of the number of EPA workers that can be recruited, the composition and number of staff (for example, the percentage of certified care workers employed in a facility), and the type of setting. The scheme may also not be sustainable because of the high cost of training, which is jointly borne by the Japanese government and the long-term care facilities, and also the lack of teachers, staff, and resources to be supplied by the facilities that are necessary for the training and exam preparations of the candidates. As a result, there was a high concentration of EPA workers employed by large groups of facilities in Kanagawa, Okayama, Aichi, Osaka, Chiba, and Tokyo. About 45% of the Filipinos were also deployed to these areas (Kubota, 2019). Facilities belonging to the same welfare organisation hire candidates who gather once or twice a week for group language studies or exam reviews.

[6] The figure is the total of candidates from Indonesia and the Philippines.

Another attempt to increase the supply of foreign workers was the revision of the TITP in 2017 to include care work. The requirements are an N4[7] Japanese language proficiency and some experience in care work (in the case of the Philippines, a nursing degree or caregiving National Competency II (NCII)[8] course) from designated developing countries (Philippines, Viet Nam, Myanmar, Nepal, Sri Lanka, Mongolia, and Indonesia, amongst others). The employers usually provide the trainees with language lessons and on-the-job training without formally enrolling them in vocational or language schools. Based on the recent revision, the trainees are allowed to stay and work in Japan beyond three years, up to five years and extendable under some conditions.

1.3. The care work student (*kaigoryugaku*) scheme

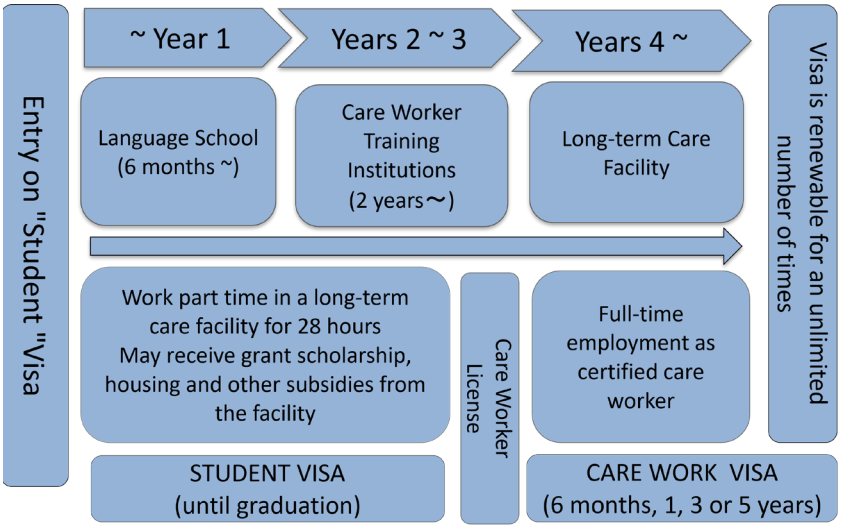
a) The scheme

The care work student pathway resulted from the creation of the 'care work' visa category in the revised Immigration Law (2017). Foreigners who have graduated from a 2-year course offered by care worker training institutions in Japan are eligible to apply to the scheme. Moreover, as an interim provision, students who graduate by March 2022 are automatically given a certified care worker license, even without passing the licensure examination, as long as the person works in a long-term care facility for five consecutive years. The duration of the visa is a minimum of one year and a maximum of five years; however, there is no limit in the number of times the visa can be renewed. The care work visa also allows its holder to bring their family to Japan. This development paved the way for the active recruitment of foreigners as students of care work (*kaigoryugakusei*).

[7] Under the Japanese Language Proficiency Test (JLPT), non-native speakers of Japanese are evaluated and certified based on five levels of proficiency, the easiest of which is N5, followed by N4, N3, N2, and the most difficult level, N1.

[8] In the Philippines, the Caregiving National Competency II (Caregiving NCII) is a 6-month technical-vocational course that trains workers in the Philippines in the provision of care and support for children, elderly and people with special needs. For details, please refer to the website of Technical Education and Skills Development Authority (TESDA) (http://www.tesda.gov.ph).

Figure 1.3: The Care Work Student Scheme



Source: Ministry of Health, Labour and Welfare (MHLW) (2018).

How a foreigner can become a certified care worker via the student pathway is shown in Figure 1.3. The person has to comply with the usual requirements to obtain a student visa, such as proof of acceptance from the learning institution (a university, training institution, or language school)[9] and a certificate from a guarantor in Japan. This visa is valid for the duration of the course in which the person is enrolled. In the case of students of Japanese language schools, the visa is valid for at least six months, and for care worker training institutions (*senmongakko* or a college), the visa is valid for two years. In many cases, the long-term care facility acts as guarantor.

To enter a care worker training institution, the student has to have an N2 language proficiency level (see footnote 6 above) or be enrolled for at least eight months in a Japanese language school in Japan. The second option is common amongst Filipino students. Language schools and care worker training institutions charge almost the same amount of tuition fees, about ¥800,000–¥850,000 yen (about US$7,200–US$7,700) per year, although students have to pay more to the latter because of the related fees for practicum and for the use of facilities and learning materials. A student is allowed to work for a maximum of 28 hours per week during school term and eight hours a day during school holidays, usually in the sponsoring long-term care facilities.

[9] Universities and training institutions set their own Japanese language proficiency entry requirement, which is usually N2 or N3.

This scheme is quite similar to the programme for caregivers offered in Canada. However, the Canadian arrangement (as of 2016) provides a faster route to working full time and obtaining permanent residency than the Japan version (as described in Nourpanah (2019)). The caregiver/aged care programme requires only seven months (minimum) of study. The student is allowed to work 20 hours per week during the term and unlimited hours during school break. After completion of the program, the student is given a temporary working visa, the validity of which will be equal to the length of the full-time study in Canada. This visa is 'open', which means that it is not tied to any employer or type of job, but the easiest job to find is as Personal Support Worker. Once the graduates have their temporary work permit, they can apply for permanent residency depending on their skill level, province of employment, and hours worked. If their temporary work permit expires while waiting for the approval of their permanent residency application, they can apply for the 'bridging work permit'.

Moreover, there is also a difference in the career pathway for care work students who are nursing graduates in their home country. In Canada, they are allowed to take further studies and testing to become a registered nurse once granted permanent residency. On the other hand, in the case of Japan, currently, it is difficult for an overseas-educated nurse, especially from the Philippines, who has taken the care worker pathway (either via EPA or student) to take the nursing licensure examination in Japan, because they cannot fulfil some requirements on nursing practicum and other subjects (with the exception of candidate nurses under the EPA).

In contrast to Japan and Canada, currently, student visas for care workers cannot be converted to working visas in Australia and New Zealand. After graduation from a course in Aged Care (Certificate in Aged Care Level 3 or Level 4), students need to return to their home country unless they obtain a visa based on other merits, such as family petition or marriage. The reason is that these countries do not classify care work as a sector with a skill shortage. Currently, the primary sources of foreign labour in the long-term care sector in these countries are permanent residents or dependents of nationals or permanent residents who can easily find work even without training or licenses in care work or aged care.

In these countries, international students who hold a nursing degree overseas can work temporarily in a long-term care facility while working on their nursing bridging or adaptation course or, sometimes, a college nursing degree. Once they complete the

course and become registered, they can function as a registered nurse and convert their visa into 'skilled migration' or 'employer sponsorship' visas, and later into permanent residency. They are free to change employer anytime so many leave care homes to work in hospitals (Carlos and Ozanne, 2019).

b) Trends in the enrolment of international students in care work

Since discussions about the creation of the new 'care work' visa category began in around 2014 in Japan, the care worker training institutions have been experiencing a remarkable increase in the enrolment of international students. In Table 1.1, we can see that the number of students reached 1,142 in FY2018, more than 67 times as many as the figure for FY2014. On the other hand, the number of Japanese students was continuously on the decline in the same period. In FY2018, international students comprised about 17% of the total student population. Such a dramatic increase in the number of international students contributed positively to the survival of these institutions where a trend of continually decreasing enrolment has been detected. In FY2018, only 44.2% of the total admission quota was filled, prompting some institutions to close down. The number of institutions

Table 1.1: Trends in the Number of Students Admitted in Care Worker Training Institutions (FY2014–2018)

Fiscal year	2014	2015	2016	2017	2018
Number of training institutions	406	379	401	396	386
Admission quota	18,041	17,769	16,704	15,891	15,506
- (%) of quota filled	57.5%	50.0%	46.4%	45.7%	44.2%
Actual admission (total)	10,392	8,884	7,752	7,258	6,856
- number of international students	17	94	257	591	1,142
- as (%) of total	0.2%	1.1%	3.3%	8.1%	16.6%

Note: The fiscal year begins in April and ends in March of the following year. It also coincides with the academic year.
Source: Compiled from Japan Association of Training Institutions for Certified Care Workers (2018).

decreased from 406 in 2014 to 386 in FY2018.

The nationalities of students have also become more diverse. Based on data from the Japan Association of Training Institutions for Certified Care Workers (2018), students from Viet Nam and China registered the most significant number of care work students (Table 1.2). In recent years, however, the number of students from countries such as Nepal (95), Indonesia (70), and the Philippines (68), the sending countries of care workers, has also been on the rise (see Table 1.2).

Table 1.2: Number of International Students Enrolled in Care Worker Training Institutions per Country of Origin (FY2013–2018)

Fiscal Year	2013	2014	2015	2016	2017	2018
Viet Nam	2	2	39	114	364	542
China	11	12	27	53	74	167
Nepal	1	0	15	35	40	95
Philippines	0	1	0	28	35	68
Republic of Korea	2	0	2	3	23	31
Myanmar	0	0	6	5	10	34
Sri Lanka	0	0	1	2	1	47
Indonesia	0	0	0	0	4	70
Others	5	2	4	17	40	88
Total	**21**	**17**	**94**	**257**	**591**	**1142**

Note: The fiscal year begins in April and ends in March of the following year. It also coincides with the academic year.
Source: Compiled from the Japan Association of Training Institutions for Certified Care Workers (2018).

This number of enrollees in training institutions, however, is expected to increase in the next few years as more potential care work students now enrolled in Japanese language schools achieve the required language proficiency level to enter training institutions. Indeed, there has been a substantial increase in students from current and potential (targeted) care worker-sending countries, such as the Philippines, Indonesia, Viet Nam, and Myanmar, enrolled in Japanese language schools as shown in Table 1.3.[10] Lastly, Table 1.3 also shows that the number of students from Viet Nam in Japanese language schools has already exceeded that of the students from China. This trend is expected to continue as Japanese private nursing homes and local governments, such as Chiba Prefecture, Saitama Prefecture, and Yokohama City actively recruit care work students in Viet Nam.

[10] Currently, in the case of students from Nepal and Sri Lanka, few are engaged in care work; many of them work as part-time staff in convenience stores, packed lunch (obento) factories, and hotel cleaning services.

Table 1.3: Number of International Students Enrolled in Japanese Language Schools (FY2013–2018)

Fiscal Year	2013	2014	2015	2016	2017	2018
China*	18,250	16,118	17,655	19,248	20,166	16,922
Viet Nam	8,436	13,758	15,715	17,334	14,761	14,440
Nepal	3,095	4,779	6,301	3,973	3,372	3,537
Republic of Korea	2,386	2,081	2,041	1,763	1,696	1,545
Taiwan	1,425	1,837	2,070	1,970	1,951	1,786
Myanmar	414	520	1,067	1,390	1,343	1,257
Indonesia	386	485	594	753	842	835
Sri Lanka	346	619	1,102	1,536	2,146	1,976
Others	310	3,470	4,302	4,311	4,436	4,487
Philippines	N/A	N/A	N/A	N/A	583	535
Total	**37,918**	**43,667**	**50,847**	**52,278**	**50,892**	**47,320**

Note: The fiscal year begins in April and ends in March of the following year. It also coincides with the academic year.
Source: Compiled from Japan Student Services Association (2018).
* Excluding Hong Kong, Macau, and Taiwan for statistical reasons.

c) Regulation of the scheme

In the case of the EPA, the Japan International Corporation of Welfare Services (JICWELS) is designated to be the sole agency that can recruit candidate care workers, in collaboration with the sending country's exclusive government agency appointed to screen applicants. This agency was established under the sanctions of the Ministry of Health, Labour and Welfare (MHLW) to implement the Japanese government's technical cooperation projects with developing countries, especially in Southeast Asia. Aside from recruitment and matching, it also conducts on-site inspections of host long-term care facilities and implements support services for candidate care workers, such as language training and reviews for the licensure examination.

On the other hand, for technical intern trainees, the government entrusts the actual recruitment and management of trainees to the supervising or implementing organisations,

which are in turn monitored by the Organization for Technical Intern Training (OTIT). The OTIT was established by the MHLW in 2017 to take on the following responsibilities: accreditation of technical intern training plans, primary screening of the applications for the licenses of supervising organisations, receipt of notifications of implementing organisations, evaluation of reports from supervising or implementing organisations, as well as onsite inspections and support and protection for technical intern trainees (OTIT website, n.d.).

Unlike the EPA and TITP, the care work student scheme is not comprehensively regulated by any single national agency in Japan. Instead, three national agencies (ministries) are involved. For the issuance of a student visa, the applicant must go through screening by the Ministry of Justice (MOJ) Immigration Bureau. The MOJ also monitors the number of hours (maximum of 28 hours per week) that students work, and imposes sanctions (such as the non-renewal of student visas or non-conversion of visas from 'study' to 'care work') on those who violate the regulations. On the other hand, Japanese language schools are under the supervision of the Association for the Promotion of Japanese Language Education, an incorporated foundation established with the approval and under the guidance and assistance of the Ministry of Education, Culture, and Sports (MEXT), the MOJ, and the Ministry of Foreign Affairs (MOFA). Finally, the MHLW accredits care work training institutions and spearheads the creation of foreign care worker schemes in response to labour market demands and the needs of the long-term care sector. In the case of the Philippines as the sending country, since people are deployed as students and not as workers, they do not go through the procedure prescribed and required of overseas workers by the Philippine Overseas Employment Administration.

Rather than the national government, the LGUs seem to play (or are expected to play) a vital role in the scheme. According to documents published by the MHLW in January 2018, the LGUs are expected to provide support to Japan-based stakeholders and students through a matching support entity, such as a council (*kyogikai*). The council, comprising of representatives from long-term care facilities, care worker training institutions, the certified care workers' association, and other private stakeholders under its jurisdiction, is delegated to gather and share information. The council is also expected to organise and coordinate orientation programmes for stakeholders. However, there are no specific provisions on whether its role can go beyond these liaison and promotional activities to cover monitoring, policing, and regulating the scheme, which, in the absence of a national agency, is deemed crucial for the success and sustainability of the care work student scheme.

d) Intermediaries in the care work student scheme

Another striking difference between the student scheme and the EPA scheme is the channel in which foreign workers are matched and recruited. As mentioned above, unlike in EPA in which only one government agency in each country (Japan and the sending country) is designated to undertake the matching and recruitment of potential care workers, private organisations become the primary facilitators of recruitment or 'intermediaries' of the care work student scheme.

Within the context of Japan's care work student scheme, we use the term 'intermediaries' to connote the private institutions (stakeholders) that are involved in the recruitment of care work students to Japan. They include the language schools, care work training facilities, long-term care facilities and foundations based in Japan, universities and colleges in the sending countries, and also the student/labour recruitment or manpower agencies and informal agents (individuals such as relatives, friends) in both countries.

These intermediaries are diverse in many aspects. First, there are intermediaries based in the sending country, or Japan, or in both countries (when a Japanese intermediary sets a branch or office in the sending country). They also vary in terms of their goals; long-term care facilities' main goal is to secure the labour force, which is rising sharply in demand, while for care worker training institutions in Japan, one of the major motives is to meet its admission quota. The goal of commercial student placement or manpower/recruitment agencies is primarily to gain profits from facilitating the mobility of students. Foundations offering free language training and schooling declare that their aim is to promote good relations between the two countries and contribute to the economic development of the sending country.

Some intermediaries recruit exclusively and directly for their own company or organisation's member facilities or schools, while some offer their services even outside their own, like in the case of a manpower agency. Finally, the intermediaries provide a broad scope of services; an intermediary may engage in recruitment only; while others deal with recruitment and training or education, or, in another case, recruitment, training, and employment. They also vary based on the tools that they use in recruitment, via word of mouth, social media or direct interaction with the students.

The role of private intermediaries is vital in the care work student scheme in the absence of a government intermediary. The Japanese market for foreign care work students is new; thus, reliable information about the conditions in both the supply and the demand sides is scarce. There are also limits and delays in accessing market information by the facilities and students because of language difficulties. In the international labour market, vast geographical distances separate sellers from buyers. In such cases, working with local intermediaries and forming a network of vertical and horizontal chains covering both countries amongst intermediaries make recruitment faster and more efficient. In the absence of government regulation regarding accreditation and guidelines on what organisations or institutions are allowed to act as intermediaries, there has been a mushrooming of such intermediaries.

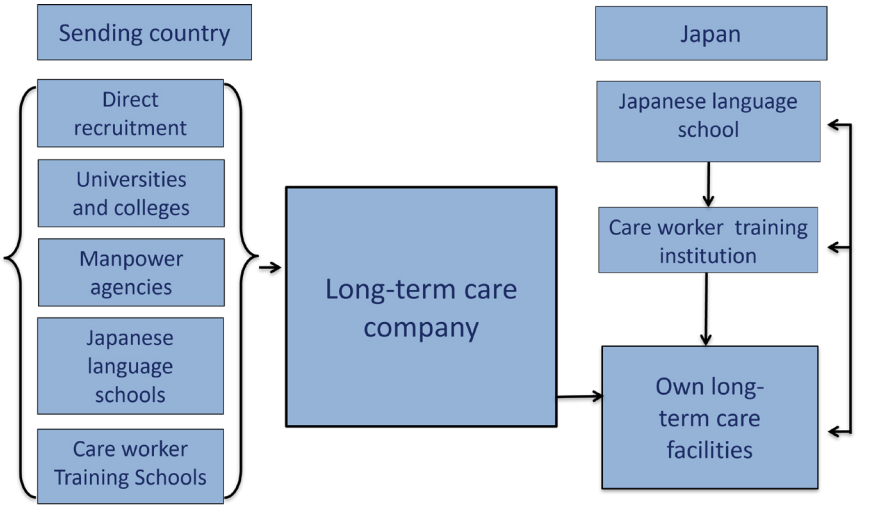
1.4. The intermediaries of the care work student scheme

In this section, we look more closely at how these intermediaries operate and collaborate to facilitate the mobility, work, and study of care workers from the Philippines. We gathered information through interviews with the managers of intermediaries and also from official websites. We also conducted interviews with Filipino students currently studying in a language school or training facility.

a) Long-term care facilities

Company Y, which owns numerous long-term care facilities in Western Japan, is one of the pioneers in bringing in foreign care workers to Japan as students. It started sponsoring five nursing graduates 10 years ago (enrolled first in a language school, then later in a care worker training school), the same year when the first group of candidate care workers under the EPA arrived from the Philippines. The company maintains a global human resources section and looks after care work students from the Philippines and Viet Nam, many of whom are still enrolled in a Japanese language school. Its staff periodically visits other intermediaries, such as Japanese language schools, manpower agencies, care work training schools, universities, and so on in the sending countries. The company also works closely with intermediaries in Japan, such as language schools, care worker training schools, and the local social welfare council, which extends its support through financial subsidies.

Figure 1.4: Recruitment Pattern of Company Y (an example)



Source: Compiled by the authors.

Figure 1.4 shows an example of how student recruitment is carried out in collaboration with a local manpower agency in the Philippines. The agency keeps a pool of potential care work students to whom they teach the Japanese language for a fee. Company Y visits the agency's branches to conduct the screening of documents, interview potential applicants, and give orientations about the company and explain the study-work scheme. The records of those who passed the testing are then brought back to Japan and processed at the Immigration Bureau for the issuance of the 'Certificate of Eligibility'. A letter of guarantee signed by the representative of the facility or the company and proof of an offer of admission (obtained from a collaborating Japanese language school or care worker training school) are also submitted. The certificate, once released, is sent to the manpower agency, which in turn submits it to the Japanese Embassy or Consulate for the application of the student visa. The agency also makes the students' travel arrangements. Company Y and the student jointly shoulder the service fees charged by the agency and other incidental and processing fees.

Company Y provides students with a part-time job in one of its facilities for a maximum of 28 hours a week. They are paid by the hour with a rate higher than the minimum wage. The company also provides subsidised furnished housing and utilities (water and electricity) and supplies them with a WiFi modem for free. Students also receive free commuting passes between the residence, the school, and the facility. They gather several times a year to participate in an orientation about Japan's way of life and culture, care

work, and also about the company. While in the language school, students have to pay for their tuition fees, but if they are accepted into a care worker training college, the company pays for their tuition fees, either partially or in full. The students do not need to pay back the tuition fees if they work in one of the company's branches full-time for five years after graduation.

b) Foundations (general incorporated associations)

General incorporated associations also act as intermediaries in the case of students from the Philippines.[11] One example is that of a foundation initiated by a president of a group of long-term care facilities and a care worker training school. Its members, many of them long-term care facilities, pay an annual membership fee to avail of the services of the foundation, such as conducting seminars and providing advice in training and employing foreign workers. It also organises Philippine study tours aimed at expanding networks with local intermediaries (such as high schools, Japanese language schools, universities, care worker training schools) and promoting (advertising) the long-term facilities that the tour participants from Japan are affiliated with.

Together with local Philippine partners, the foundation opened a Japanese language school in the Philippines. The students, all of them nursing graduates, studied on a full-time basis. They also get free tuition, housing, and a stipend. Of the members of the first batch, three were chosen based on their performance in school and on language and were sent to Japan to enrol in a Japanese language school. Two who achieved C-level in the Test of Practical Japanese[12] were allowed to enter a care worker training school and are expected to graduate in March 2019.

In Japan, one of the association's member facilities became the sponsor of the two students, providing free tuition fee, subsidised housing and a monthly allowance. The students may choose to work part-time for up to 28 hours a week. After graduation, they will be employed full time by the same facility, and, based on verbal agreement, they are expected to work there for three years.

[11] A general incorporated association (ippan shadan houjin) in Japan is an entity whose activities and legal standing are quite similar to a foundation or non-governmental organisation.
[12] Commonly known as the J-Test, C-level is roughly equivalent to N2 of the Japanese Language Proficiency Test).

c) Japanese language schools

The role of Japanese language schools is crucial in the care work student scheme because in most cases, international students do not have the Japanese language proficiency level to enter a care worker training institute. In the case of School N, which has a Japanese language department and a care worker training department, it not only actively recruits and educates international students but also matches the students with their future (after graduation) employers that in turn provide them with a tied scholarship.

The programme works as follows: students, usually those who already have nursing education, are recruited from the school's own or affiliated language schools in the sending country. In Indonesia, the school has an arrangement with local universities and colleges to introduce the programme to their graduates and it maintains an office in two universities to handle inquiries about studying and working in Japan. In the case of the Philippines, it accepts students through a manpower agency that also owns a language school where applicants (usually graduates of nursing) learn basic Japanese.

The language school looks after the students, from opening a bank account to applying for the residency permit card, settling in the school dormitory, and securing a part-time job in a nearby facility. A few months before their graduation from the language course, the school organises an event in which students undergo matching or pairing with long-term care facilities that are willing to sponsor their care work education and employ them full-time after graduation. Students decide based on the salary and working conditions, the location (prefecture and city), and work setting (long-term care, disabled or rehabilitation). While students are enrolled in the school's own care worker training department, they are encouraged to work part-time in the sponsoring facility during school breaks and during practicum (when possible). Now in its third year, the matching programme has attracted facilities from all over Japan.

d) Manpower agency in the sending country

Manpower Agency M is one of the most popular local intermediaries for care work students in the Philippines. It was established as a sending organisation for technical intern trainees to Japan and has now expanded its business to Japanese language training, Japanese-English language translation and interpretation services, business consultations and development, Philippines and Japan visa assistance, and Japan study-work-live (Japan

Student, Japanese Language Training and Japan Caregiver) programmes. In addition to care work, this agency recruits Filipinos as technical trainees and interns for the hospitality (hotels) sector. This agency, which maintains offices in Manila, Davao, and Cebu, has affiliations with technical intern trainees' accepting organisations, consulting and referral agencies, manpower and outsourcing companies, and vocational and Japanese language schools in Japan. In the case of care work students, the graduates of medical- and health-related courses, such as nursing, are preferred. The agency offers them free Japanese lessons and processing of documents, and also a 'fly-now, pay-later' package for those who cannot afford to pay for the pre-departure expenses.

The manpower agency usually conducts recruitment activities through social networking services, particularly Facebook, through its website and by word-of-mouth. The typical process that potential students undergo is as follows: First, those interested are invited to attend a one-day career orientation programme to familiarise themselves with the available pathways to Japan, the requirements, as well as the estimated time and costs for deployment. Those who decide to avail of the agency's services are then required to enrol in the Japanese language and cultural training. This programme, which is registered with the Philippine Technical and Skills Development Authority (TESDA), takes three months full-time to complete and costs approximately US$300. The student pays for the language and culture programme fees, assistance in the processing of documents, one-way airfare, and other necessary expenses for deployment to Japan. The manpower agency also charges the language school or the long-term care facility that sponsors the student in Japan with recruitment fees.

1.5. The care work students' perspective

Private stakeholders, both in Japan and the sending countries welcomed the launching of the care work student scheme. Even before the passing of the bill, intermediaries had already begun recruiting potential students through social media and TV advertisements and were offering Japanese language lessons. The students' responses have also been overwhelming as they entertain high hopes of being able to work in Japan after their studies.

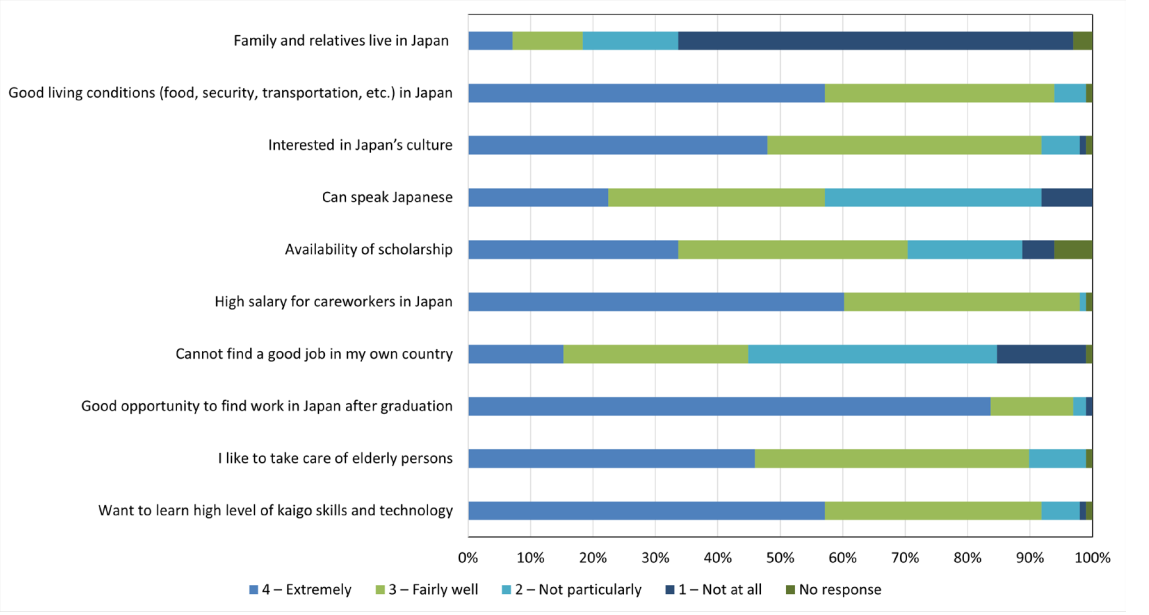
In order to capture the current conditions and perceptions of the care work students from the Philippines, we implemented a survey in September 2018 during an orientation seminar for care work students in Western Japan. In the survey, we asked questions

regarding their educational and employment background, motivations to study in Japan, current concerns regarding their life and study, perceptions on being part-time care workers, and their future plans. Here, we present the partial results of the initial survey of 98 respondents, 84.7% of whom are female; 88.7% are aged between 25 and 34 years old, and 86.7% are unmarried. Regarding their educational background, 58.2% have a Philippine nursing license, and 67.3% are graduates of a four-year Bachelor of Nursing degree in the Philippines. Since the scheme has just been implemented recently, many (94.8%) of those who answered the survey arrived in Japan between February 2017 and August 2018.

a) Motivations to study in Japan

Figure 1.5 presents the responses of the students when asked the question, 'To what extent do the following reasons for studying *kaigo* in Japan match your own?' When the percentage of those who answered 'extremely' and 'fairly well' were added, economic-related reasons, 'high salary for care workers in Japan' (98.0%) and 'good opportunity to find work in Japan after graduation' (96.9%), topped the list. Many Japanese consider care work as a low-paying job, but the respondents did not think so, probably because they were comparing it with other countries or regions, such as Taiwan and Singapore, where nursing aides and live-in caregivers receive less. It could also be because of their perception that salaries in Japan, in general, are much higher than in the Philippines. Coming to Japan as students is part of the respondents' 'migration project' with the goal of getting hired in Japan in the future.

Figure 1.5: Motivations to Study Care Work in Japan (n = 98)



Note: Answers to the question: 'To what extent do the following reasons for studying *kaigo* in Japan match your own? (1 – Not at all, 2 – Not particularly, 3 – Fairly well, 4 – Extremely).
Source: Authors' calculations from survey data (2018).

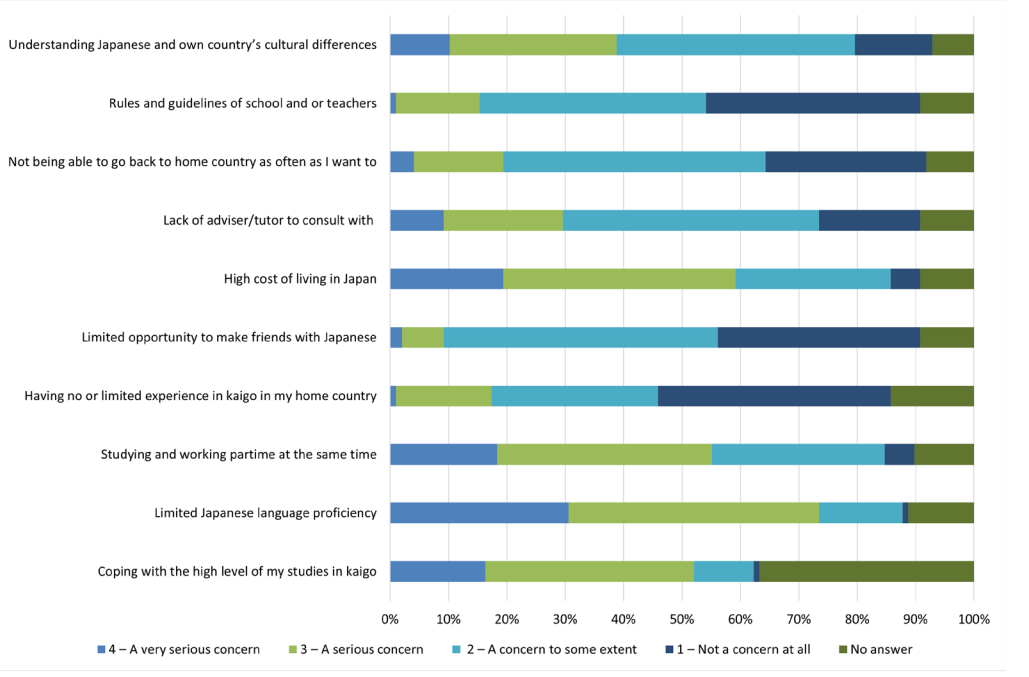
The quality of life in Japan is also one of the strong motivations for the care work students. One student interviewed said that she appreciated the convenience of trains, feeling safe walking the streets even at night, and also the freshness and wide variety of food choices. Many students also expressed a liking for Japanese food. They seemed to enjoy being immersed in the Japanese culture. One interesting result from our survey is that 91.8% of the respondents (some of those who answered 'extremely' and 'fairly well') feel that their interest in the Japanese culture (especially popular culture, such as manga and cosplay) favourably influenced their decision to come to Japan. In contrast to this, previous similar surveys implemented amongst Filipino professional nurses, care workers and nursing students (see, for example, Carlos (2013:15) and Nakai, Goto, and Carlos (2008)), interest towards Japanese culture did not appear to have a strong influence in the respondents' decision making. Our result indicates how Japan has been gaining success in promoting its culture in Asia and how 'soft culture' can be utilised to attract young foreign workers to the country.

Finally, more than half (57.1%) of the respondents answered that being able to speak Japanese motivated them 'extremely' or 'fairly well' to come to Japan. The students' desire to learn the Japanese language is proof of their interest in Japanese culture. Moreover, they also felt an advantage in knowing the language, especially when going back to the Philippines. They thought they could easily find good-paying jobs in call centres that handle Japanese customer services and as bilingual staff for Japanese-owned companies.

b) Concerns and issues as care work students

In the survey, we also asked the students about several foreign care workers' concerns and issues. The replies ranged from 'not a concern at all' to 'a very serious concern'. Capturing which concerns affected them the most will allow policymakers and stakeholders to address the concerns in an effective and timely manner. Figure 1.6 shows our results.

Figure 1.6: Issues and Concerns of Care Work Students (n = 98)



Note: Answers to the question: To what extent do you consider the following as your concern (problem/issue) as a *kaigoryugakusei* in Japan? (1 – Not a concern at all, 2 – A concern to some extent, 3 – A serious concern, 4 – A very serious concern).
Source: Authors' calculations from survey data (2018).

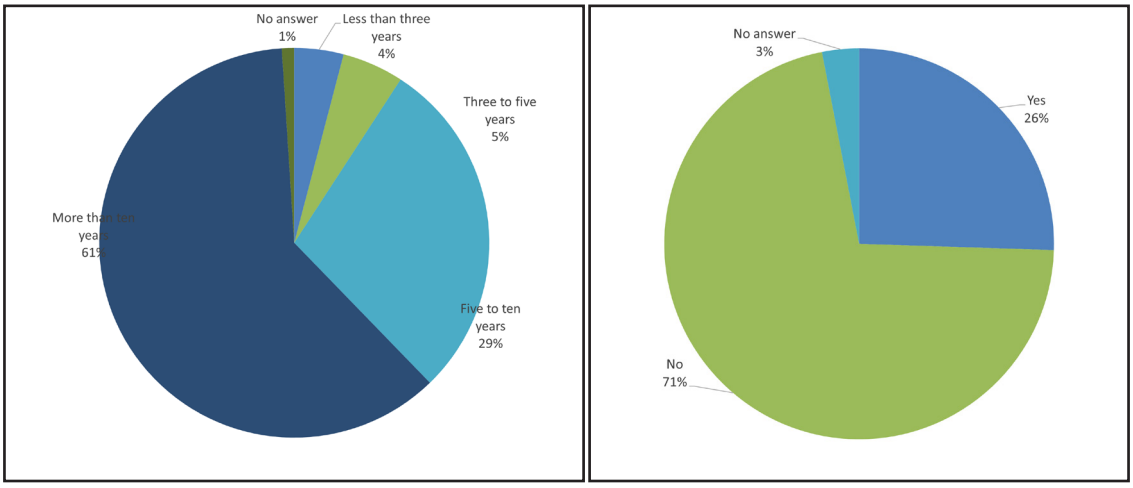
As predicted, most (73.5%) of the respondents thought that their limited Japanese language proficiency was a 'very serious' or 'serious' problem, primarily because they arrived just recently (within six months from the time of survey). They also felt anxious about how to cope with their lessons held in Japanese when they enter a care work training school. One male respondent also mentioned that he could not imagine how he could manage to do the elderly residents' documentation and charting without command of the Japanese language. Indeed, the language problem has been a long-standing issue for all Filipino care workers, regardless of the pathway through which they joined the Japanese labour market.

The high cost of living, studying, and working (part-time) at the same time, and coping with the high level of their studies in care work were also important issues for the respondents. Given their limited number of hours to work part-time and the many expenses they need to pay, such as their tuition fees and housing and daily needs, many of the language school students said they find it hard to make ends meet. It also emerged from informal interviews that many of them remit money to their families back home to support them and pay off some loans they contracted to finance coming to Japan.

c) Future plans

As mentioned above, one of the main issues in the EPA is the high attrition rate, even in the case of those who have already obtained the license. Considering that the severe labour shortage is an issue that is expected to haunt Japan for quite some time, and the time and the cost of training care workers, it is ideal that the students remain in Japan for long. To inquire about how care work students think about their future, we asked how long they aspire to work in Japan for and their desire to work in another destination. The survey shows that 61.2% want to work in Japan for at least 10 years. Furthermore, 28.6% plan to stay in Japan between 5 and 10 years (see Figure 1.7). One reason for this trend is the number of years, usually three to five, that is required by the sponsoring facility to write off their student loans. One respondent also mentioned that she plans to stay for at least five years so that she can apply for permanent residency and bring her family to Japan.

Figure 1.7 (a) Planned Duration of Working in Japan (left) and (b) Plan to Work in Other Countries (after Japan) (right)



Note: Answers to the question: (a) After you graduate and obtain the license, how long do you plan to work as care worker in Japan? (b) Do you have any future plans to work in other countries (after Japan)?
Source: Authors' calculations from survey data (2018).

Within the context of the culture of migration and unpredictable and ambiguous foreign worker policies in popular destinations, it is common for an immigrant to work from one transit destination to another until that person reaches the most desired or the final destination (for details, see Carlos (2013)). When we asked the students if they have plans to work in another destination (after Japan), three out of four answered in the negative. The reasons that the respondents gave were geographical proximity between the Philippines and Japan, their fondness of Japanese culture and way of life, and the availability of a secure job when they graduate. These findings imply that the care work student scheme can be a potential long-term solution to the labour shortage as long as their concerns are addressed.

1.6. Summary and policy suggestions

In this report, we introduced the care work student scheme formalised in 2017 as one pathway for foreign care workers in Japan. Under the scheme, they must enrol in a care worker training institution in Japan for two years. During that time, they are permitted to work for 28 hours, usually in a long-term care facility that sponsors their study and stay in the country. Upon graduation and passing of the national licensure examination (with a special exemption for those who graduate by March 2022), they obtain the 'certified care worker' license. They then convert their student visa into 'care work', which allows them to work full time, usually in the same (sponsoring) facility. The visa is initially valid for a maximum of five years and is renewable.

This scheme is the second formal pathway for foreign care workers in Japan. The first was the EPA scheme in which candidate care workers from Indonesia (since 2008), the Philippines (since 2009), and Viet Nam (since 2015) are recruited to Japan to work in a long-term care facility for three years, after which they are allowed to take the national licensure examination. Passing the test will entitle them to stay in Japan to work, otherwise (in principle), they must return to the home country. The third scheme is the technical internship scheme in which foreigners are trained to become care workers on the condition that they return to their home country to share what they learned in Japan.

One of the most striking differences between these schemes lies in the roles that the national and LGUs assume in its operation and regulation. First, JICWELS in the case of EPA, and OTIT in the case of TITP, are entrusted by the Japanese government to comprehensively implement the rules and regulations and monitor the respective schemes. In the case of care work students, there is no single public entity with such roles. Second, while matching and recruitment in EPA are done solely by the agencies representing the governments of Japan and the sending country, in the care work student scheme, these tasks are left to various intermediaries from the private sector. In this report, we introduced several intermediaries and explained how they collaborate to bridge the students who are eager to work in Japan and the schools and long-term care facilities that are keen to admit or hire them.

Currently, the scheme is mostly private-led, with many intermediaries from the private sector forming networks to facilitate their recruitment, training, and employment. From our interviews, it appeared that many Japanese stakeholders prefer this scheme over the EPA or TITP because the graduates are systematically and intensively trained in the Japanese way of care work in a *formal* school setting. They can also obtain a better command of the Japanese language, including technical terms.[13] While it takes two years before they can work full time, being students not only enables them to acquire the skills but also provides them with a good and comprehensive understanding of the long-term care insurance system and Japanese laws, opportunities to learn the Japanese way of doing things, and understanding of the language and culture, giving them more confidence in their work. The students interviewed did not feel uneasy with the obligation to work full-time for three

[13] During our fieldwork, some EPA candidates pointed out their concerns with regards to the way they learn the language and care work skills because of lack of time (they have to study and work at the same time) and non-cooperative host institutions.

to five years after graduation in exchange for a scholarship from a facility. They were even happy that they would have an employer after graduation. These observations from the private stakeholders suggest that this pathway may gain more popularity in the future. In our initial preliminary findings regarding the perceptions of care work students from the Philippines, we found that they are attracted not only with the economic rewards but also by the good quality of life and popular culture of Japan. Many also expressed their intention to remain in Japan as candidates for more than five years. As students, they are most concerned with their Japanese language proficiency and the high cost of living. These suggest that the scheme can potentially supply a stable labour force in the care work sector in the long run, as long as their concerns are properly and immediately addressed.

To further promote and sustain this scheme, we recommend that the public sector, in its various capacities, complements the efforts of the private sector. There is a need, however, to carefully examine what roles they can take on. In the case of the national government, it can establish an agency or at least assign a lead agency for which the potential functions can be the comprehensive coordination and monitoring of activities conducted at the LGU level. It can also act as the coordinating body amongst the three ministries involved in the scheme. Another possible role that this national agency can take is to support the LGUs to spearhead its activities, such as establishing a local matching support entity. Assistance is essential, particularly for smaller LGUs with a small budget and staff who have limited experience in facilitating the recruitment, looking after international students, and dealing with different cultures.

There is also a need to look at the inconsistencies that arise from the various schemes. For example, while EPA candidates are allowed more time than is normally allotted to take the written part of the licensure examination, care work students do not have the same privilege. Lately, the Japanese government also approved the 'specified skills number 1' visa, another scheme for foreign care workers. As the number of available options increases, there is a need to clearly lay out their commonalities and differences to help foreign care workers and employers decide the best option. There is also a need to examine the possibility of shifting between schemes, like, for example, in the case of a care work student or EPA candidate wanting to convert the student visa into the 'specified skill number 1' visa. A national inter-agency council can be organised to address these issues.

As mentioned above, in the care work scheme, the LGUs, rather than the national government, are expected to play a more central and active role. Currently, there have been diverse reactions from the LGUs. While some have been very active, even acting as a go-between amongst stakeholders in the sending country and Japan, there are also LGUs that do not have collaboration yet with private stakeholders within their jurisdiction. This attitude is understandable as the constituency expresses mixed reactions towards hiring foreign care workers. The extent of the labour shortage also varies amongst LGUs, and there are areas where, so far, the local labour force can fill up vacant places in care work. LGUs have their social welfare and economic priorities as well as resource limitations. In these cases, LGUs would instead take a 'wait and see' stance and organise their activities later after learning from the shortcomings, and adopting good practices from the LGUs that were involved earlier on.

The LGUs can adopt activities similar to those of other LGUs that have run pioneering programmes of collaboration with private stakeholders. In the case of Osaka Prefecture, it created a council that drafted a set of detailed guidelines for the smooth implementation of the scheme. The guidelines contain provisions about the terms of student scholarships and loan schemes (for example, who can avail of them, how they must be administered and repaid, and so on) and rules and limitations (particularly labour and immigration laws) that facilities must be aware of when employing the students as part-time care workers. Japanese stakeholders are also encouraged to exert efforts in assisting the students to lead a healthy and comfortable life in Japan, like, for example, by establishing student consultation counters and counselling and listing down important points in dealing with the cultures and religions of the sending countries. It also introduces the legal aspects, concerns, and implications in cases of recruiting as a consortium (a group of facilities and schools) and via a manpower or recruitment agency. Finally, it also contains rules to be followed in hiring former students as full-time employees after graduation in terms of, for example, drafting the employment contract, determining the salary, and so on (Osaka Prefecture Social Welfare Council, 2018). These guidelines are critical not only in the smooth operation of the scheme but also in promoting the welfare of the foreign care workers.

On the other hand, Hokkaido's Kamikawa district's case is an example of how smaller LGUs can pool their resources to promote the scheme. In December 2018, three municipalities, namely Higashikawa, Horokanai, and Takasu, allied to create the Council for Fostering Foreign Nursing Care Workers' Human Resources Development. The council, whose

members are representatives from each LGU and eight long-term care facilities within the area, will work together to assist foreign care work students. It announced that it would provide a scholarship amounting to ¥2.5 million per student that will be used to subsidise the tuition fees and cost of living from fiscal year 2019 (Nikkei News Online, 2018).

There are also cases when LGUs act as the coordinator between the local and sending countries' major stakeholders. For example, Yokohama City concluded MOUs with the LGUs of Ho Chi Minh, Danang City, and Hue Prefecture, as well as with several universities and care worker training institutions in these areas. They will collaborate in recommending and deploying students to Yokohama City. For its part, Yokohama City will coordinate with the local facilities in providing part-time jobs and, later on, full-time jobs to the students. The city will also subsidise students' tuition fees in the language and care work training schools, and also their rent while housed at a public apartment complex (Yokohama City website, 2018). Indeed, there are numerous ways and avenues that the public sector can contribute to making the scheme work. The success of the scheme does not only depend on the private sector's and the care work students' efforts but also in the way that the government sector, especially the LGU, complements and addresses their concerns. Addressing the needs of the students and protecting their welfare, both as students and workers, are also keys for their retention. Japan, being the country with the highest proportion of the elderly population and a shrinking workforce, is challenged to seek effective ways on how public–private active collaboration and coordinated support can be carried out alongside exploring alternative feasible schemes to accommodate foreign workers in the care sector.

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2

Career Development of Foreign-Trained Nurses in Malaysia

Yuko Tsujita and Hisaya Oda

Abstract

This chapter analyses foreign-trained nurses in Malaysia. Based on our survey of 104 foreign-trained nurses, we discuss the characteristics of working as a licensed or unlicensed nurse in Malaysia, why the nurses came to Malaysia, and their willingness to go to other countries. The results suggest that most of the licensed nurses work in private hospitals, while the unlicensed nurses work in nursing homes and private duty nursing. High salary and benefits play an important role in attracting foreign-trained nurses. However, Malaysia is largely regarded as a stepping stone for future career development. The intention to emigrate is quite high amongst the sampled nurses, particularly the Malaysia-unlicensed nurses. Malaysia needs to consider foreign-trained nurses' long-term career development when private healthcare facilities resume recruiting foreign-trained nurses in the future.

Keywords: International migration, health and hygiene, nurses, Malaysia, India

1. Introduction

Malaysia is one of the nurse-receiving countries in Asia. It was reported the country was suffering from a shortage of nurses. This was mainly attributable to the ageing of the local nursing workforce, growing demand for health care, and the emigration of Malaysian nurses (Barnett, Namasivagam, and Narain 2010). Moreover, the government's 'Malaysia My Second Home' programme requires more nurses who are able to deliver high-quality medical services for foreign nationals, especially older persons.

The Government of Malaysia has implemented various measures to overcome the shortage of nurses. There was a time when private hospitals relied heavily on foreign-trained nurses who had nursing licenses for their home countries. Malaysia signed agreements with seven countries, Albania, Bangladesh, India, Indonesia, Myanmar, Pakistan, and the Philippines, to allow their licensed nurses to practice nursing in Malaysia (Matsuno, 2009). In 2007, 40% of the nursing workforce in private hospitals was foreign-trained nurses (ibid.). In the peak year in 2009, 1,031 foreign nurses from non-ASEAN member states were newly registered, and the number of registered ASEAN nurses was 286.[1] However, the total number of foreign-trained nurses has declined to 52, as listed in the Nursing Board in 2018. This is mainly attributable to Malaysia promoting nursing education for its own nationals. The late 2000s witnessed the mushrooming of private nursing schools that produced as many as 10,000 graduates every year. As a result, the number of nurses had increased significantly by the early 2010s (World Health Organization, 2014). There were 42,836 local nurses in 2006, and this figure became more than double (87,476) by 2012.[2] As the number of local nursing graduates increased, the number of foreign-trained nurses declined gradually, and many health facilities are currently not actively recruiting foreign nurses.[3]

Over the decades, the degree of nurse labour market openness to foreign-trained nurses changed from time to time, depending on the country's medical care, immigration, labour, and employment policies so as to overcome a shortage of nurses. However, little has been researched on foreign-trained nurses in Malaysia. To our knowledge, this is the first attempt to analyse issues and challenges related to them. This chapter investigates foreign-trained nurses in Malaysia with a particular focus on (1) characterising the socio-economic characteristics of foreign-trained nurses in Malaysia; (2) investigating the factors influencing their decision to work in Malaysia; (3) describing their working experiences in Malaysia; (4) understanding the relationship between remittances and migrants; and (5) identifying the factors influencing the decision to migrate from Malaysia to other countries.

[1] http://nursing.moh.gov.my/wp-content/uploads/2018/10/Statistik-ASEAN-Registered-Nurse-Workforce-31-Dec-2017.pdf (accessed on 7 January 2019).
[2] Same as footnote 1.
[3] There are criteria to employ foreign-trained nurses. For example, see the website (http://nursing.moh.gov.my/wp-content/uploads/2017/07/Criteria-for-employment-of-foreign-trained-nurses-in-Msia-17072017.pdf). According to an informant in October 2018, health facilities have to advertise vacant positions seven times for local nurses before recruiting foreign-trained nurses.

The structure of this chapter is as follows. Section 2.1 provides a literature review. Section 2.2 outlines the data collection process. Section 2.3 explains the basic characteristics of the sampled nurses. Section 2.4. illustrates the factors influencing their coming to work in Malaysia. Section 2.5 briefs their working experiences. Sections 2.6 explains the relationship between remittances and migrants. Sections 2.7 and 2.8 analyse the factors influencing the decision to move from Malaysia to another country. The final section summarises our findings and concludes.

2. Empirical Analysis

2.1. Literature review

A traditional push-pull factor analysis on migration explains that nurses migrate overseas mainly to achieve a higher salary, better working resources and conditions, more opportunities for training, transparent promotion, exposure to new advanced knowledge and technology, skill enhancement, higher occupational status, and so on in the destination countries (e.g. Kline (2003), Kingma (2006)). They are also compelled by 'push' factors, such as lower wages, poor working conditions, and so on in the country of origin. These push and pull factors are two sides of the same coin. From the nurse-receiving country's perspective, it is important to understand the pull factors towards providing training, education, and the working environment and conditions for foreign-trained nurses.

Migrants frequently change location from one country to another for better conditions until they settle in the final destination, or they repeat moving back and forth between the destination and their home country. In the process of career development, nurse migration is not an exception (for example, Carlos (2013), Paul (2015)). By examining cases of Filipino nurses, Carlos (2013) explains that nurses, for example, migrate first to a Gulf country, such as the United Arab Emirates and Saudi Arabia or to Singapore where they gain practical experience as a nurse and then migrate to another country for betterment. This process, called 'stepwise migration', continues until they reach a preferred destination, such as Australia or Canada.[4] At the same time, when nurses reach their final destination, it is noted that nurses from the developing countries tend to be engaged in simpler tasks

[4] The migration pattern of travelling back and forth between the destination and the home country is called 'circular migration'. According to the definition by the United Nations, a circular migrant is defined as a person who crosses the national borders of the reporting country at least three times over a 10-year period, each time with the duration of stay (abroad or in the country) of at least 90 days (UNECE, 2016).

than local nurses or those from developed countries (O'Brien, 2007; Yeates, 2009; Bruyneel et al., 2013). This is attributable partly to the fact that a nursing career in other countries, particularly developing countries, is not often recognised by developed countries (Bach, 2003). Many foreign-trained nurses face structural obstacles, such as immigration policies, language and communication issues, racism and discrimination, acculturation, and nursing practice issues, that impede the pathway to become registered nurses in the destination country (Cuban, 2010; Moyce et al., 2015). As some foreign-trained nurses enjoy satisfactory careers and positively contribute to the nursing workforce in the destination country, it is imperative to examine who, why, and how foreign-trained nurses develop their career in the destination country.

A nurse's job satisfaction plays a significant role in the intention to leave the workplace in Malaysia. A study in a teaching hospital reports that 40% of the staff nurses intend to leave their employment, and the most important determinant of this is the low degree of job satisfaction (Ramoo et al., 2013). Updating knowledge and providing quality care are considered to be the most important factors that motivate nurses to participate in continuing professional education in Malaysia (Chong et al., 2011). In the Malaysian hospital and health care setting, some aspects of career development, including motivation to work, job satisfaction, and future prospects for foreign-trained nurses, need to be examined.

2.2. Methods

a) Survey participants

The survey participants are those who were born in overseas countries, studied nursing outside Malaysia, obtained a nursing license abroad, and are currently working as a nurse or any related occupations in Malaysia, excluding those working in the academic field.

In Malaysia, foreign-trained nurses in clinical areas that meet the criteria stipulated by the Nursing Board are qualified as registered nurses, and their employers comply with formal procedures to register them with the Malaysia Nursing Board.[5] Due to the currently growing size of the local workforce and the restrictive government policy on recruiting foreign-

[5] For details, see the website (http://nursing.moh.gov.my/wp-content/uploads/2017/07/Criteria-for-employment-of-foreign-trained-nurses-in-Msia-17072017.pdf).

trained nurses, according to the information provided by the board, the number of foreign nationals in the register is only 52, comprised of 32 from India, 7 from the Philippines, 3 from Singapore, 3 from the United Kingdom, 3 from the United States, and 1 each from Indonesia, Japan, Ireland, and Viet Nam. As there is no complete list available to us of who is in the register, we tried to cover as many Malaysia-registered foreign-trained nurses as possible using the snowball sampling technique, whereby respondents introduced us to their colleagues and friends, after a female nurse research assistant identified the first survey participant through her ex-colleagues' networks. At the same time, we found there were unlicensed foreign nationals working in nursing homes, etc. As there is also no official list of such people, i.e. they are not registered nurses in Malaysia, we also employed the snowball sampling technique whereby we identified the first survey participant through our local collaborator, the University of Putra Malaysia's social networks, and collected data from those complying with our criteria.

The sample size of 104 comprises 24 people with a nursing license in Malaysia and 80 who do not have a nursing license in Malaysia, based on our financial and time constraints.

b) Data collection

This survey of foreign-trained nurses in Malaysia was conducted from October 2018 to January 2019. The surveys were principally conducted using a questionnaire including items covering the person's personal profile, nursing education details, career development, and information about working in Malaysia. The questionnaire was seven-and-a-half pages of A4 in English. Question types were multiple choice, closed, and descriptive.

A female Malaysian nurse enumerator visited Malaysia-licensed nurses working mainly in hospitals in and around Kuala Lumpur, the capital city of Malaysia. At the same time, a male Filipino nurse enumerator visited Malaysia-unlicensed nurses. The questionnaire survey was administered in-person by the enumerators. The nurses were usually interviewed outside their work location hospital. The interview took an average of 40–60 minutes, excluding an initial 'ice-breaking' time when the enumerators met the respondents. The language of the survey was mainly English. However, if the Filipino nurses needed to elaborate on a question, the enumerator would elaborate using the local language in the Philippines. In parallel with the questionnaire survey, we also met some unsampled nurses from abroad, and Malaysian employers in nursing homes and those who hire or dispatch foreign-trained nurses. These interviews are indicated as in-depth interviews in this chapter.

2.3. Brief characteristics of the sampled nurses

The number of respondents in this study was 104. Twenty-four were registered with the Nursing Board and are defined as Malaysia-licensed nurses; 80 were not registered with the Nursing Board and are defined as Malaysia-unlicensed nurses. By nationality, 31 were from India (23 Malaysia-unlicensed and eight Malaysia-unlicensed nurses), 69 from the Philippines (all Malaysia-unlicensed nurses), and four from Pakistan (one Malaysia-licensed and three Malaysia-unlicensed nurses) (Table 2.1). In terms of the workplace, whether they were Malaysia-licensed or not, all the sampled foreign-trained nurses worked in the private sector. Of the 24 Malaysia-licensed nurses, 22 worked in private hospitals and most of them work in the intensive-care unit in some specific hospitals. In contrast, the Malaysia-unlicensed nurses worked in nursing homes (38 nurses),[6] or in private duty nursing (38 nurses).[7] These two sectors are not regulated by the Malaysia Nursing Board, i.e. the employers do not have to comply with formal procedures to register the employees with the Nursing Board.

Table 2.1: Basic Profile of the Sampled Nurses

	Malaysia-licensed	Malaysia-unlicensed	Total
No. of observations	24	80	104
Country of origin			
India	23	8	31
Philippines	0	69	69
Pakistan	1	3	4
Workplace			
Private hospital	22	1	23
Private clinic	0	3	3
Nursing homes	1	38	39

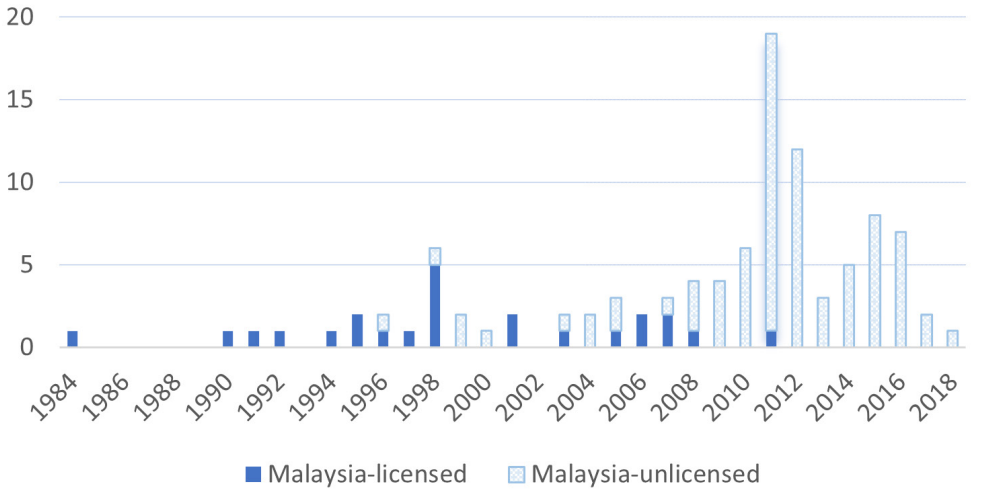
[6] Some of the sample nurses reported that foreign-trained nurses in nursing homes earn RM1,800–2,000 per month.
[7] Private duty nursing is individual (health) care with the main purpose of rehabilitation, and temporary illness and long-term care for older persons. Our sampled nurses indicated that Malaysian-national nurses can earn RM25 per hour for private duty nursing, while Filipino nurses who are not registered by the Nursing Board of Malaysia can earn only RM15–20 per hour; RM10–13 per hour is paid to Filipino caregivers who do not have a Filipino nursing license; and RM4,000–5,000 per month for Indonesian male nurses.

Private duty	0	38	38
Non-profit organisation	1	0	1
Gender			
Male	4	28	32
Female	20	52	72
Marital status			
Single	2	36	38
Married	22	35	57
Widowed/separated/divorced	0	9	9
Legal residential status			
Permanent resident	11	1	12
Non-permanent resident	13	79	92

Source: Authors' survey.

The Malaysia-licensed nurses tended to have a longer career experience than their counterpart Malaysia-unlicensed nurses (Figure 2.1). On average, the former group had 18.7 years of nursing experience, while the latter only 7.3 years. Eleven of the sampled Malaysia-licensed nurses (45.8%) had permanent residency in Malaysia, i.e. they are married to a Malaysian and settled in Malaysia. Those who were not married to a Malaysian would work in the same hospital, and they were brought back by the former employer after a cooling-off period, currently three months.

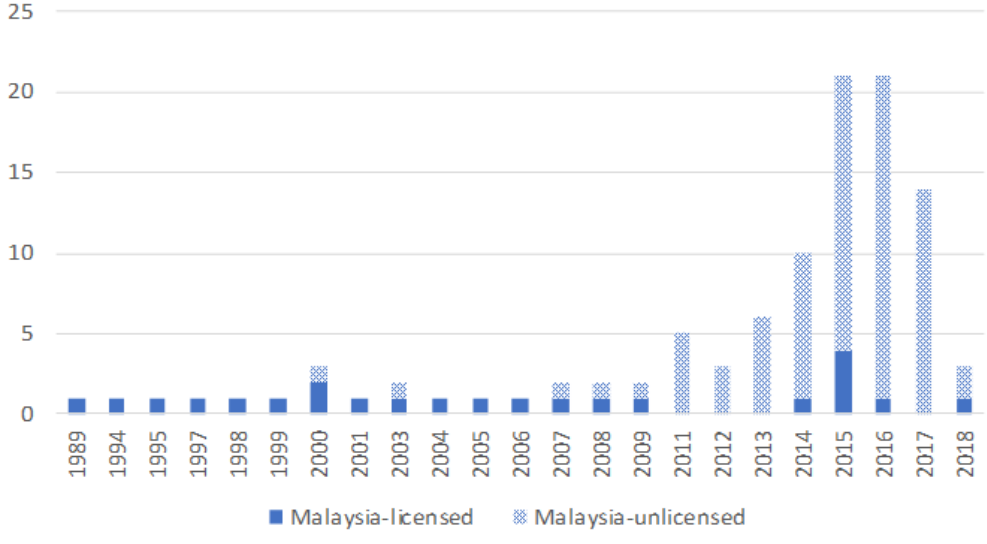
Figure 2.1: Year When the Sampled Nurses Obtained Their First Nursing Degree



Source: Authors' survey.

As the sampled nurses' careers show, the Malaysia-unlicensed nurses tended to have arrived in Malaysia in recent years. Approximately three-quarters of the unlicensed nurses arrived in Malaysia since 2014 (Figure 2.2). This implies that most unlicensed nurses are unlikely to stay in Malaysia for a long time. We will discuss this issue in sections 2.7 and 2.8.

Figure 2.2: Year of Arrival in Malaysia



Source: Authors' survey.

It is worthwhile mentioning that it is not at all common for Malaysia-unlicensed nurses to become Malaysia-licensed nurses. All of the sampled Malaysia-licensed nurses were licensed nurses from the beginning of their tenure in Malaysia. Foreign-trained nurses need to obtain a temporary practicing certificate from the Nursing Board through their employer if they are assigned to a registered nurse position. In contrast, most of the Malaysia-unlicensed nurses do have valid work permits. They are not in the hospital sector, and their employers are not regulated by the Nursing Board. Therefore, it is not possible for them to obtain a certificate. Moreover, foreign-trained nurses currently require at least three years of clinical experience after they complete their nursing studies and pass the specialisation exam in nursing. Of the Malaysia-unlicensed nurses, 18 (22.5%) had obtained their nursing degrees within the last three years, and it was impossible for them to accumulate years of clinical experience as nurses because their experience working in nursing homes and private duty nursing is not regarded as clinical experience. At the same time, demand for foreign-trained nurses is not low because it is not easy for nursing homes and agents for nurses to find Malaysian nurses to work for them.

2.4. Factors related to working in Malaysia

Why do nurses come to Malaysia? Table 2.2 shows the most important reason why they come. Malaysia-licensed nurses arrive in Malaysia because their family and/or relatives are there (11 nurses), closely followed by higher salary and benefits (nine nurses). Malaysia-unlicensed nurses are attracted to Malaysia due to the higher salary and benefits (46 nurses). Eight Malaysia-unlicensed nurses pointed out the low recruitment and processing fees to come. Indeed, 58 Malaysia-unlicensed nurses (43.8%) answered that the financial cost of migration to Malaysia is somehow manageable, followed by easily manageable (29 nurses, i.e. 36.3%). Only 15 Malaysia-unlicensed nurses (18.8%) answered that they think it is hard to manage the cost of migration.

Table 2.2: Most Important Reasons to Come to Malaysia

	Malaysia-licensed		Malaysia -unlicensed	
	N	%	N	%
Higher salary and benefits	9	37.50	46	57.50
Family/relatives live there	11	45.83	3	3.75
Low recruitment and processing fees	0	0.00	8	10.00
Self-respect	0	0.00	7	8.75
Better quality of life	1	4.17	5	6.25
High level of nursing skill	0	0.00	6	7.50
Interested in the country's culture	1	4.17	2	2.50
Can obtain citizenship	2	8.33	0	0.00
Can bring family	0	0.00	1	1.25
No answer	0	0.00	1	1.25
Children's education	0	0.00	1	1.25
Total	**24**	**100**	**80**	**100**

Source: Authors' survey.

To understand foreign-trained nurses' motivation to come to Malaysia more comprehensively, we asked to what extent they experienced difficulties in being a nurse in their country of origin on a four-point scale: '1' not at all difficult or no problem; '2' not particularly difficult or no problem; '3' fairly difficult/problematic; and '4' extremely difficult or problematic. The results are given in Table 2.3. As is shown, Malaysia-unlicensed nurses reported facing significantly higher difficulties or problems across a wide range of nursing aspects. Focusing on the scale points given by Malaysia-unlicensed nurses, they gave highest points (greatest difficulties) to the items of 'low salary and fewer benefits' (average scale point: 2.86), 'high ratio of patients to nurses' (2.85), and 'connection/corruption in getting employed and promotion' (2.80). Given the fact that the overwhelming majority of Malaysia-unlicensed nurses in the sample are from the Philippines, we compared the results with our previous tracer survey of alumni of a nursing college in the Philippines. The results show exactly the same trend. Nurses in the Philippines face the three problems

mentioned above, in particular. These problems seem to accelerate their motivation to work abroad.

Table 2.3: Difficulties in the Sampled Nurses' Country of Origin

	Malaysia-licensed		Malaysia -unlicensed		
	Mean	Std. dev	Mean	Std. dev	
Dealing with patients	1.54	0.15	2.26	0.08	***
Occupational hazards	1.83	0.16	2.56	0.08	***
Limited opportunities for career development	2.25	0.20	2.69	0.08	**
High ratio of patients to nurses	2.33	0.22	2.85	0.09	**
Low salary/fewer benefits	2.96	1.19	2.86	0.09	
Connection/corruption in getting employed and promotion	2.04	0.22	2.80	0.09	***
Inadequate facilities/infrastructure in hospitals	1.54	0.17	2.75	0.09	***
Poor working conditions	2.25	0.24	2.75	0.09	***
Difficult relationship with supervisors and fellow workers	1.71	0.19	2.49	0.08	***
Lack of nursing skill and knowledge	1.75	0.19	2.19	0.09	**
Gender discrimination by patients	1.54	0.13	2.16	0.09	***
Gender discrimination by management	1.50	0.15	2.07	0.09	***

Note: *** indicates that the difference between the means by students' t-test is greater than zero at a significance level of 1%.
Source: Authors' survey.

Further, we asked why the sampled nurses chose to study nursing when they were admitted to their first nursing degree course. Table 2.4 shows the results. Malaysia-licensed nurses chose nursing due to the high employability (six nurses), followed by working overseas (four nurses). However, unlicensed nurses chose nursing to help their families financially in the future (25 nurses), followed by higher salary and benefits (23 nurses). Interestingly, only 19 (23.8%) of the Malaysia-unlicensed nurses chose nursing based on their own motivations, showing that family and/or relatives play an important

role in choosing to study nursing. As 41 (51.3%) of the Malaysia-unlicensed nurses had a person working abroad from their family or a relative, families and relatives might also be a push factor for becoming a nurse and going abroad even if they are unlicensed in the destination.

Table 2.4: Most Important reasons to Become a Nurse

	Malaysia-licensed		Malaysia -unlicensed	
	N	%	N	%
I would like to help my family financially in the future	2	8.33	25	31.25
Higher salary and benefits	3	12.50	23	28.75
To work overseas	4	16.67	12	15.00
To provide service to the sick and needy	3	12.50	13	16.25
Ease of finding a job/Employability	6	25.00	3	3.75
Owing to family encouragement	2	8.33	2	2.50
To achieve a better social status	1	4.17	1	1.25
I was not admitted to other courses	1	4.17	0	0.00
My ambition	1	4.17	0	0.00
I was interested in nursing	1	4.17	0	0.00
Missing	0	0.00	1	1.25
Total	**24**	**100**	**80**	**100.00**

Source: Authors' survey.

2.5. Working experiences in Malaysia

How did the sample nurses evaluate their nursing career development in Malaysia? We asked the sampled nurses what the advantages or disadvantages of working in Malaysia were in their opinion. As Table 2.5 shows, high salary, skill enhancement, experience, and career development were the most popular advantages assessed by the sampled nurses, regardless of their Malaysian Nursing Board license status, while some differences between Malaysia-licensed and unlicensed nurses can be found. For example, more Malaysia-unlicensed nurses reported that it was easy to find a job, easy to work, and there

were easy procedures for the work (no statistical test done). In fact, our in-depth interviews revealed that some come to Malaysia under a tourist visa, and later change their status to stay legally in the country, often using the service of an agent. They can easily find a job after arriving in the country. This ease is inextricably linked to unclear contracts. Malaysia-unlicensed nurses in in-depth interviews indicate that no proper job description or contract is signed. Some nurses complained that the job description, particularly for private duty nursing, is at the mercy of the employer. Sometimes, they do household chores as well as health/elderly care. According to them, the employers in nursing homes and private duty nursing do not understand their professional medical knowledge and experience, even if the Malaysia-unlicensed nurses are registered nurses in their country of origin.

Table 2.5: Advantages and Disadvantages of Working in Malaysia Assessed by the Sampled Nurses (multiple answers)

Advantages	Malaysia-licensed	Malaysia-unlicensed
High salary	11	22
Skills and experience, career development	6	15
Easy to find a job	0	17
Easy to work (job and the environment)	1	9
Easy procedure to work	0	6
Cost of living easy life	0	5
Multi-race and cultural diversity	4	0
Quality of life	3	0
Self-respect	2	0
No strict code of ethics	0	1
Geographical proximity	1	0
Easy to live (religion, culture, etc.)	0	1
None	3	0
Total no. of answers	**31**	**76**

Disadvantages	Malaysia-licensed	Malaysia-unlicensed
Racism/discrimination	4	13
Not recognised as a nurse	0	14
No job description/no contract	0	14
Language/communication	4	4
Getting work permit difficult	0	8
No job scope/no further education/career development	4	3
Lack of benefit for foreigners	1	5
Paper work	4	0
Home sick	1	3
Getting permanent residency/citizenship not easy	4	0
De-skilled/cannot use professional skills	0	4
Busy	2	1
Cannot bring spouse/family	2	0
Lack of job opportunities	0	1
Others	0	12
None	4	4
Total answers	**30**	**86**

Source: Authors' survey.

It is noteworthy that the sampled Malaysia-unlicensed nurses were likely to work longer than the Malaysia-licensed nurses. On average, the unlicensed nurses worked for 67.3 hours per week. In contrast, the average working hours per week for the Malaysia-licensed nurses was 43.9 hours weekly. The number of night shifts also significantly differs between the two groups. We asked the number of maximum and minimum nights per month they were on duty. The Malaysia-unlicensed nurses had, on average, a maximum of 12.0 night shifts and a minimum of 7.7 night shifts per month. Indeed, some private duty nursing requires only night shifts. However, the corresponding figures for the Malaysia-licensed nurses were a maximum 7.9 nights and minimum of 3.6 night shifts per month. As Malaysia-unlicensed nurses' working hours tend to be longer and their night shifts are much more than the Malaysia-licensed nurses, they are more vulnerable to illness, which was pointed out in our in-depth interviews with the Malaysia-unlicensed nurses.

As for their current satisfaction in career development in Malaysia, we asked 'Are you currently happy to choose nursing as your profession?'. Answers were given on a five-point scale: 1 = very unhappy; 2 = unhappy; 3 = neither unhappy nor happy; 4 = happy; and 5=unhappy. Malaysia-licensed nurses scored 3.63 on average, which is significantly lower than the average score (4.20) for the Malaysia-unlicensed nurses. We will further explore this issue in section 2.7.

2.6. Nurse migration and remittances

Out of the 104 sampled nurses, 91 nurses sent money back to their countries in the 12 months prior to the interview. The ratio of remittance incidence was 87.5%. Under the theory of New Economics of Labor Migration (Stark and Bloom, 1985), labour migration is considered as one of the family strategies to overcome several constraints and risks facing the migrant-sending family. It assumes that there is a reciprocal informal agreement between the migrant family and the migrant. The family finances the cost of migration and takes the roles that the migrant would have played at home during her/his absence. In return, the migrant remits money back home to fulfil the other part of the agreement.

However, a closer look at the data reveals some differences between Malaysia-licensed and unlicensed nurses. One such difference is the high ratio of remittance sending amongst unlicensed nurses and the low ratio of remittance sending amongst licensed nurses. Seventy-eight out of 80 unlicensed nurses (97.5%) remitted while only 13 out of 24 licensed nurses (54.2%) did so (see Table 2.6). Furthermore, there are a couple of notable characteristics amongst the 11 licensed nurses who did not transfer money to their families back home. Firstly, all eleven nurses were female and married at the time of interview, 6 of whom were married to Malaysians. Secondly, eight nurses held permanent resident status. These reflect that when a woman forms a new family with her husband or becomes a member of her husband's family after marriage, and as her tie with her original family becomes weaker, this results in the reduction or cessation of remittances (Raihan and Siddique, 2017).

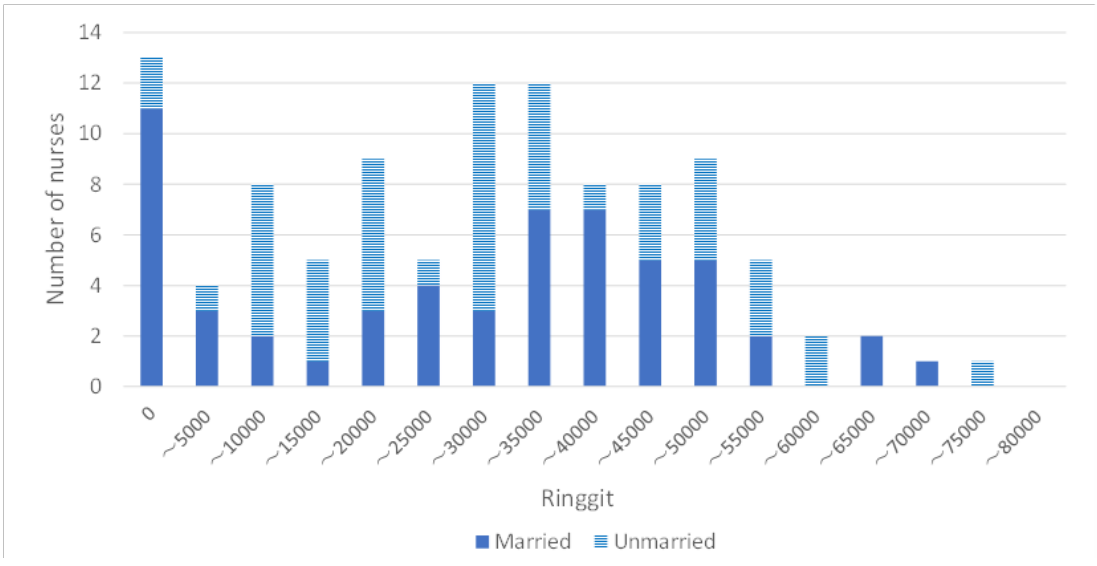
Table 2.6: Incidence of Remittances amongst the Sampled Nurses

	Yes	No	Total
Licensed	13	11	24
Unlicensed	78	2	80
TTL	91	13	104

Source: Authors' survey.

The average amount of remittances in the last 12 months amongst nurses who remitted (total 91 nurses) was RM29,607 (RM1 = US$0.25), with a maximum value of RM70,000 and a minimum value RM300, while the overall average of all sample nurses including those who did not remit was RM25,907 (see Fig. 2.3 for the distribution of remittances). The average amount of remittances amongst married nurses was RM24,087, and the amount for unmarried nurses was RM24,860.

Figure 2.3: Distribution of the Volume of Remittances



Source: Authors' survey.

On average, married nurses remit less, but the difference is not statistically significant, and around 50% of married nurses did not wire money back home.[8] This is probably due to the fact that the majority of unmarried nurses in our sample were unlicensed and working in private nursing homes or on private duty. These nurses tend to earn less than licensed nurses working in private hospitals. Only two nurses out of the 47 unmarried nurses were licensed, while 22 out of 57 married nurses were licensed.

Table 2.7 shows how the remittances are spent by the recipients. The most frequent use of the remittances is for financing the day-to-day needs of the family, and the second-most frequent is for education for the associated children or siblings. These are typical uses of workers' remittances and have been reported in existing literature (for example, see Oda (2007)). What is different from ordinary labour migrants in terms of the utilisation of remittances is that quite a number of the sampled nurses said that their remittances are accumulated in the form of personal savings. A little bit more than one-third of nurses who remitted for the last 12 months reported this. The 'personal saving' here probably means that the remitted money is accumulated for use in the future when the nurses return home. Nurses usually come from middle-class families, not from families in lower-income groups. Hence, they do not need to spend the entire remittances on daily needs or other items but can afford to keep some amount as personal savings for future use. In our sample, the education levels of the nurses' parents were relatively high. Eighty-six out of 104 fathers, and 84 of 104 mothers graduated from high schools, and 34 fathers and 42 mothers had university degrees and above (see Table 2.8). Only two fathers and one mother did not complete their primary school education. These high education levels in general indicate the overall good standard of living of nurses' families. For Malaysia-unlicensed nurses, their motivation to become nurses was mainly to help their family financially and attain a high salary and benefits or overseas employment. This result shows that the nurses accomplished their initial intentions that they had when they decided to become nurses.

[8] The t-statistics for the difference between the two averages is 0.607, showing no statistical difference between them.

Table 2.7: Utilisation of Remittances amongst the Sampled Nurses' Families

Utilisation	No.
Day-to-day needs of your family	80
Education of children/siblings	55
Personal saving	37
Pay existing loans	26
Pay for family's medical treatment	18
Purchase a car/motor vehicle	17
Purchase a house/land	14
Wedding	8
Investment (jewellery, gold, stocks)	8
Other	1

* Multiple answers
Source: Authors' survey.

Table 2.8: Education Levels of Nurses' Parents

Education levels of nurses' parents	Father		Mother	
	No.	%	No.	%
University graduate and above	34	32.7%	42	40.4%
Higher secondary school	12	11.5%	10	9.6%
High school	40	38.5%	32	30.8%
Middle school	11	10.6%	14	13.5%
Completed primary	5	4.8%	5	4.8%
Below primary	2	1.9%	1	1.0%
Total	104	100%	104	100%

Source: Authors' survey.

2.7. Stepwise migration of nurses from Malaysia

The tendency of stepwise migration or re-migration to another country amongst sampled nurses was highly observed. The ratio of nurses who answered yes to the question of whether they had plans to migrate to another country from Malaysia was around 70%. Seventy-three out of 104 nurses responded 'yes' (See Table 2.9). Given this number, it is evident that many of the interviewed nurses see Malaysia as a stepping stone to their next or final destination. In particular, a stronger tendency for the intention to re-migrate is seen in the group of unlicensed nurses. Amongst the 24 licensed nurses, 11 nurses had intentions to migrate, as did 62 of the 80 unlicensed nurses. Close to 80% of the unlicensed nurses said they plan to leave Malaysia for their next destination. A similar result is obtained when the sample data are divided into permanent residents and non-permanent residents. Amongst the 12 nurses possessing permanent resident status, only four nurses had intentions to migrate. On the other hand, 69 of the 92 non-permanent resident nurses, or 75%, said they plan to leave for their next destination (see Table 2.10). The interpretation of these results is that nurses who have a legitimate status, such as being licensed and/or permanent residency, are likely to remain in Malaysia because their jobs are more secure, and probably their working environments are far better than nurses who lack such statuses.

Table 2.9 : Ratio of Intention to Re-migrate to Another Country by Registration Status

	Licensed	Unlicensed	Total
Yes	11	62	73
No	13	18	31
TTL	24	80	104

Source: Authors' survey.

Table 2.10: Ratio of Intention to Re-migrate to Another Country by Permanent Resident Status

	Permanent	Non-permanent	Total
Yes	4	69	73
No	8	23	31
TTL	12	92	104

Source: Authors' survey.

Table 2.11 shows the next preferred destinations for the nurses who planned to migrate from Malaysia to another country. It seems that many of the nurses did not have concrete plans. Hence, the countries listed here are considered as their wish-lists. As may be expected, Western countries, such as the United States, the United Kingdom, Canada, and European countries are ranked top. Nursing positions in the Gulf countries, such as the United Arab Emirates and Saudi Arabi, also appealed to the sampled nurses. These countries usually do not provide citizenship to foreign workers, so they cannot be considered as final destinations.[9] They are seen as another stepping stone to other preferred destinations.

Table 2.11: Next Destination Countries for Nurses

Destination	No.
United States	22
United Kingdom	14
Canada	14
Gulf countries	10
Europe (any)	9
Australia	7
New Zealand	3
Singapore	3
Netherland	3
France	3
Japan	2
Others	4
No idea	2

* Multiple answers
** Asked those who plan to migrate
Source: Authors' survey.

[9] See, for example, the homepage of the UAE government for the information regarding its citizenship (https://government.ae/en/information-and-services/passports-and-traveling/uae-nationality).

The nurses listed various reasons for re-migration. The most important reason for nurses' leaving Malaysia was for upgrading their nursing skills, knowledge, and career development (see Table 2.12). Thirty-four out of the 73 nurses who planned to migrate answered this as the reason for moving to another country. This was followed by 'looking for more opportunities to practice as a nurse', as answered by 11 nurses. Migration for a higher salary came third. However, if the reasons are divided into two categories based on whether the nurses are licensed or unlicensed, some significant differences emerge. If fact, the top two reasons – 'for skills/knowledge/career development' and 'for more opportunities to practice as a nurse' – are heavily dominated by answers from unlicensed nurses. Only one licensed nurse answered that she would like to migrate to obtain skills and knowledge, and none of the licensed nurses said that they planned to leave for more opportunities as a nurse.

These answers reflect the job status and working conditions of unlicensed nurses. As already noted, unlicensed nurses basically work either in private nursing homes or do private duties largely at someone's house mainly to take care of the sick and/or older persons, and most of these duties do not require the professional skills and knowledge of nurses but rather those of caregivers. Such working environments, which contribute to the de-skilling of nurses, motivate them to leave for another country to upgrade their skills and knowledge as nurses. In addition, since they are unlicensed in Malaysia in spite of holding valid nursing certificates from their country of origin (and also due to the nature of their work), they are neither officially nurses in Malaysia nor recognised as nurses by patients or the people they are caring for. Such lack of recognition as a nurse is also a motivating factor for them to plan further migration.

There is a very important point to note here. Although unlicensed nurses feel the disadvantages and drawbacks of being nurses in Malaysia, their level of job satisfaction in general is quite high. Section 2.4 reports that the level of satisfaction amongst Malaysia-unlicensed nurses is significantly higher than the average level of the Malaysia-licensed nurses. The point is that they plan to migrate not because they are not happy with their current jobs in Malaysia, but because they would like to improve their career prospects by obtaining higher skills and knowledge necessary for finding nursing job opportunities in their preferred destinations.

Table 2.12: Reasons for Re-migration amongst Nurses Who Plan to Re-migrate

Reasons for re-migration	Licensed nurses	Un-licensed nurses	Total
For skills/knowledge/career development	1	33	34
For more opportunities to practice as a nurse	0	11	11
For higher salary/money	4	5	9
As a stepping stone	0	5	5
To get permanent residency/formal work permit/stable job	3	2	5
For better life	1	3	4
For seeking for promotion opportunities	1	1	2
For children's education	1	1	2
To explore other countries	0	2	2
For better working environment	1	0	1
Others	2	2	4

* Multiple answers
Source: Authors' survey.

2.8. An analysis of characteristics affecting nurses' plans to migrate

So far, we have looked at whether nurses plan to migrate from Malaysia to another country by categorising their status as licensed or unlicensed. However, there are of course other possible factors that may motivate nurses to plan re-migration. This section statistically characterises nurses who planned to re-migrate and compares them with nurses who did not plan to migrate. Here, we divide the expected factors affecting the likelihood of the nurses' re-migration into four categories and statistically examine the differences for each factor. The categories are: (1) individual and family characteristics, (2) nurses' status and variables related to their jobs in Malaysia, (3) financial conditions of the nurses' families, and (4) factors related to the nurses' education. Fisher's exact tests as well as independent t-tests are used for the analysis. The results are shown in Table 2.13.

Individual and family characteristics include the nurse's gender, marital status, religion, country of origin, and whether a member of his/her family or relatives works abroad as a nurse. For the analysis of marital status, nurses who were divorced or widows are dropped. For the country of origin, nurses from Pakistan are dropped. These are dropped due to the small number of samples. As for religion, the data is divided into Christians and others (i.e., Hindus and Muslims).

Amongst these, the gender and the country of origin of the nurse are significantly related with the likelihood of having a plan to re-migrate. Male nurses and Filipino nurses are more likely to plan to migrate than female and Indian nurses. Indian nurses tend to be married and, in particular, married to local Malaysians. Because of this, their mobility is limited compared to Filipino nurses.

Variables related to nurses' education are represented by the type of school from which the nurse graduated, the year of obtaining the first degree, and who motivated him/her to become a nurse. The types of school considered are a typical government-run school or a private school. Semi-government schools are included in the category of government schools. The person who motivated him/her to become a nurse is divided into two categories: the nurse's own decision or a decision influenced by others, such as parents or relatives. This is included to see how such decision-making is related to stepwise migration. The results show that none of these variables caused significant differences in the tendency of the nurses to plan further migration.

The financial conditions of the nurses' families seem to significantly affect nurses' motivations for re-migration. Two factors are considered. One is whether the nurse's family borrowed money to finance his/her nursing education. The other is whether the nurse remitted money to the family in the last 12 months before the interview. The tendency of having a re-migration plan is higher amongst nurses from families that took loans for financing their nursing education. Likewise, it is higher amongst nurses who remit money to their families. The reason for these results is that nurses plan to re-migrate for betterment in order to support their families back home and repay loans.

In order to scrutinise variables related to nurses' statuses and nurses' plans to migrate, the following five factors are examined: whether the nurse is a licensed or unlicensed nurse; whether the nurse is a permanent or non-permanent resident; whether the nurse works either in a private hospital or in a nursing home/on private duty; the nurse's year of

arrival in Malaysia; and the level of happiness of working as a nurse in Malaysia. The results indicate that nurses who are unlicensed and who are non-permanent residents have a higher tendency for planning re-migration compared to licensed nurses and those holding permanent resident status. As for the workplace, the ratio of planning further migration is higher amongst nurses working in private nursing homes or doing private duties compared to nurses in private hospitals. There is also a significant difference in the arrival years of nurses who have plans to migrate and those who do not. On average, the nurses who arrived later are more likely to have plans to migrate than those who arrived earlier. As for the level of happiness, there are no significant differences. Both types of nurses are equally happy to work in Malaysia.

The nurses' license status, permanent resident status, and their type of workplace are highly correlated, as Table 2.1 demonstrates. Nurses who are licensed usually have permanent resident status and work in private hospitals, while nurses who are unlicensed tend not to be permanent residents and work in nursing homes or do private duties at someone's house. The Malaysia-licensed nurses are not interested in exploring further opportunities abroad as they have legal status to stay in Malaysia for the long term and work as licensed nurses in hospitals. As a result, their tendency to have a plan to re-migrate is low. On the other hand, the unlicensed nurses' motivation to leave is high as they are not permanent residents, not recognised as nurses, and have to endure the risk of being fired at any time. These gaps cause differences between licensed nurses working in private hospitals with permanent resident status and unlicensed nurses working as caregivers in nursing homes or doing private duties without permanent resident status in terms of the nurses' aspirations to seek better opportunities abroad.

Table 2.13: Results of Statistical Analysis of Influencing Nurses' Re-migration[1]

Variables	Number of nurses who plan to migrate	Proportion of nurses who plan to migrate	Difference	
Individual and family characteristics				
Gender				
Male	28/32	0.875	0.250	**
Female	45/72	0.625		
Marital status				
Single	29/38	0.763	0.096	
Married	38/57	0.667		
Religion				
Christian	54/75	0.720	0.120	
Others	15/25	0.600		
Country of origin				
India	17/31	0.548	-0.205	**
The Philippines	52/69	0.754		
Member of family/relatives abroad as a nurse				
Yes	38/51	0.745	0.085	
No	35/53	0.660		
Nursing education				
Type of school				
Government	15/21	0.714	0.015	
Private	58/83	0.699		
Years of obtaining the first degree[a]				
Plan to migrate		2007.9	-1.123	
No plan to migrate		2009.0		
Decision to be a nurse				
Self-decision	15/25	0.600	-0.134	
By others	58/79	0.734		

Financial condition of family				
Loan to finance nursing education				
Yes	35/44	0.795	0.188	**
No	31/51	0.608		
Remittance				
Yes	68/91	0.747	0.363	***
No	5/13	0.385		
Job and status in Malaysia				
Licensed nurse in Malaysia				
Yes	11/24	0.458	-0.317	***
No	62/80	0.775		
Permanent resident status				
Yes	4/12	0.333	-0.417	***
No	69/92	0.750		
Type of workplace				
Private hospitals	11/23	0.478	-0.288	***
Nursing homes/private duties	59/77	0.766		
Year of arrival in Malaysia[a]				
Plan to migrate		2013.8	4.628	***
No plan to migrate		2009.2		
Level of happiness[a]				
Plan to migrate		4.137	0.234	
No plan to migrate		3.903		

***, **, * indicate 1%, 5%, and 10% level of statistical significance.
[(1)]Fisher's exact test is employed to analyse the difference between two proportions except[(a)], which uses the independent -test of differences between two sample means.
Source: Authors' survey.

3. Concluding remarks

This chapter analysed foreign-trained nurses in Malaysia. Based on our survey of 104 foreign-trained nurses, we discussed the characteristics of working as a licensed and unlicensed nurse in Malaysia, why the nurses came to Malaysia, and their willingness to go to other countries. The results suggest that most of the licensed nurses work in private hospitals, while the unlicensed nurses work in nursing homes or carry out private duty nursing. The high salary and benefits play an important role in attracting foreign-trained

nurses. However, Malaysia is regarded as a stepping stone for future career development, especially by Malaysia-unlicensed nurses. The intention to emigrate was quite high amongst the sampled nurses, particularly those who were unlicensed nurses and non-permanent residents. This implies a higher salary might not be sufficient for foreign-trained nurses to stay at first-destination countries for a long time.

One of the important areas identified in the Eleventh Malaysia Plan 2016-2020 is private healthcare. To achieve this goal, more nurses are required to increase the development of the private healthcare sector. The number of nursing students has recently declined due to the tighter admission policies and limited financial support for nursing students. Moreover, some private hospitals in Singapore actively recruit Malaysian nurses. In the future, private health facilities might need more nurses from abroad and need to be attractive to foreign-trained nurses. This chapter shows that the financial incentives are not enough for foreign-trained nurses to stay in Malaysia for the long term. Moreover, aged care facilities suffer from a shortage of nurses and caregivers, since Malaysian nurses and nationals do not prefer to work in the elderly care sector. Private health facilities and elderly care facilities need to consider foreign-trained nurses' long-term career development.

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Nurse Migration and Career Development: The Indonesian Case

3

Aswatini Raharto and Mita Noveria

Abstract

Indonesia is known as an important origin country of labour migration, mainly to some countries in Asia (Malaysia, Taiwan, Hong Kong, and Singapore) and to the Middle East, especially Saudi Arabia. However, the healthcare workforce, including nurses, has not been a major constituent of Indonesian migrant workers abroad.

National data show that Indonesia did not achieve the target ratio of 180 nurses for 100,000 population in 2019, based on the number of nurses working at health facilities. However, some provinces have already reached over the target. Therefore, the nurse workforce distribution within Indonesia in the context of nurse internal migration is an important issue. International nurse migration is also increasingly important (mainly work as caregivers from Indonesia to work abroad), referring to the increasing number of those deployed to work overseas. In addition, the ASEAN Economic Community (AEC), which was established at the end of 2015 is facilitating the free movement of skilled labour within ASEAN Member States, including nurses, and will increase the opportunity for Indonesian nurses to migrate and work in other ASEAN countries.

The survey conducted in Jakarta and the surrounding areas mainly focussed on the analysis of Indonesia's nurse migration, both internal and international. The survey shows that nurses as international migrant workers from Indonesia have been working in some Asian, Middle Eastern, European, and even African countries, with Japan as the main destination amongst Asian countries. The reasons for working abroad, the pull factors of the destination countries, are mainly for getting more experience, skill improvement, and better career advancement. Amongst the nurses who did not have any experience working abroad, most of them were

also not interested in working abroad mainly due to family constraints. Regarding the push factors in the country, problems that the nurses experienced in their job might have had a positive influence on their intention to work abroad. Career development seems to be a problem amongst nurses. Although they have fulfilled several requirements needed as nurses, some stated difficulties and a lack of satisfaction with career development in Indonesia. Nevertheless, this was not a prime factor pushing them to migrate and look for a job abroad.

Keywords: nurse, international migration, internal migration, career development, Indonesia.

1. Introduction

Indonesia has a long history of sending labour to work overseas, and it is also known as an important origin country of labour migration, mainly to countries in Asia (Malaysia, Taiwan, Hong Kong, and Singapore) and to the Gulf countries, especially Saudi Arabia (Aswatini, 2017a; Aswatini, 2017b). International labour migration from Indonesia increased substantially in the 1970s in response to growing demand from the Gulf countries, especially for male migrant labour from Asian countries, including Indonesia, to work in infrastructure projects. This was followed by increasing demand for female domestic workers that resulted in the phenomenon called the 'feminisation of migration', as large numbers of female migrant workers, especially from Indonesia and Sri Lanka, entered the domestic labour market in the Gulf countries (Asis, 2005).

The healthcare workforce, including nurses, has not been a major occupation source amongst Indonesian migrant workers abroad, but Indonesia has a history of sending nurses to the Netherlands. This programme was developed at the request of the Dutch government for sending Indonesian nurses to join the healthcare sector in the Netherlands. The first batch of Indonesian nurses arrived in 1969 but, unfortunately, this programme was suspended in 1974 for several reasons (Hosen and Raharto, 2013: 393). Even after the cessation of the programme with the Netherlands, there has been a growing demand for nurses in the global labour market of the healthcare workforce, and this can be a pull factor for motivating Indonesian nurses to work abroad.

The shortage of nurses is rampant all over the world irrespective of development status (Matsuno, 2009; NurSearch, 2017; Marc et al., 2018; World Health Organization, 2018). The World Health Organization (WHO) estimated that the world would need an additional 9

million nurses and midwives by the year 2030, and Southeast Asia and Africa are the areas which have the greatest demand. Looking at developed countries, such as the United States, the United Kingdom, and some European countries, 77% of the countries are facing a nursing staff shortage, and nearly all of the countries rely on the supply of nurses from abroad, especially from developing countries (Rutter, 2001: 1172; Li, Nie, and Li, 2014). Matsuno (2009), Miyamoto and Seoka (2015), Marc et al. (2018), Nagaya (2018) and Hadad and Toney-Butler (2019) also showed that some developed countries, such as the United States, Japan, and some European countries such as the United Kingdom and Germany, have experienced shortages of nurses. Shortages have also been seen in some developing countries in Africa, such as Somalia, Niger, and Burundi (NurSearch, 2017)

Miyamoto and Seoka (2015), Marc et al. (2018), Nagaya (2018), and Hadad and Toney-Butler (2019) explain that there are some important factors causing the nurse shortages in developed countries, such as ageing populations (which increase the need for health services); ageing workforces, including the nursing workforce; and the withdrawal of nurses from the labour market due to both pecuniary and non-pecuniary factors, such as family-related reasons and working conditions. In developing countries, the significant loss and shortage of the nursing workforce are caused by the low quality of nursing school education, which does not meet needs (mismatch between production and demand), and high nurse out-migration, mainly from low- and middle-income countries to high-income countries (Ross, Polsky, and Sochalski, 2005; Li, Nie, and Li, 2014; Rosskam and Kurniati, 2014; Tangcharoensathien et al., 2018; Efendi et al., 2018).

Within ASEAN member countries, the movement of nurses from one country to other ASEAN member countries was facilitated by the establishment of the ASEAN Economic Community. Its 2025 Blueprint facilitates the free movement of skilled labour within ASEAN for eight occupations, including nursing (ASEAN Secretariat, 2015). This might be a factor that positively influences the movement of nurses, causing them to work outside their countries in other ASEAN Member States.

1.1. The Indonesian nurse workforce

In 2017, a total of 345,276 nurses worked at health facilities in Indonesia, and the ratio of nurses to the total population was 131 for every 100,000 people (Kurniawan et al., 2018). The total number of nurses registered for membership of Indonesia's National Nurse Association (*Persatuan Perawat Nasional Indonesia*/PPMI) was 359,339 in 2017 (Ministry of Health, 2017:

4). These data indicate that not all of the nursing workforce (about 14,063 nurses) is being utilised in Indonesia's health facilities. The government's target ratio for 2019 was 180 nurses for every 100,000 population. To achieve this target ratio, Indonesia had 137,258 vacancies for nurses in health facilities as of 2019, based on the 2017 data. There is also an uneven distribution of nurses in Indonesia. If we look at the differences in the nurse-to-population ratio by province in Indonesia, only 16 of 34 provinces have more than 180 nurses per 100,000 population.

Nurses represent the largest proportion of the health workforce in Indonesia (29.66% in 2016). However, there is no exact data available on the total number of nursing school graduates that can indicate the available nursing workforce (supply of the nursing workforce) due to the lack of a human resources information system in Indonesia (Efendi et al., 2018). A WHO report in 2009 showed that 682 schools offered nursing education in Indonesia and produced 34,000 nurses per year. The number of nursing schools/institutions increased to 889 in 2014, offering mainly bachelor's degrees and Diploma III (Ministry of Education and Culture in Efendi et al., 2019).

Referring to the increase in the number of nursing schools/institutions and the approximate number of graduates, it can be supposed that Indonesia no longer has the problem of a nursing workforce shortage. The problem is the imbalanced distribution of the nurse workforce. As a result, there are surpluses in some provinces (Jakarta Capital Region, East Kalimantan Province, and Bangka Belitung Islands Province) and shortages in some other provinces (Ministry of Health, 2017). Indonesia also has potential resources for sending nurses to work abroad if the quality of graduates and qualifications are fulfilled by the potential nurse migrant workers. Referring to the situation above, the internal as well as international migration of nurses are important issues to be explored in Indonesia.

1.2. The study

This study, entitled 'International Migration of Indonesian Nurses', was carried out in Indonesia with the Special Capital Region of Jakarta as the basis of the study area. Because of the ageing population in the world, including Indonesia in the future, the need for care workers (nurses and caregivers) in the countries experiencing ageing population problems will be one factor influencing the international migration of care workers. In Indonesia, this will also influence the internal migration of care workers amongst provinces due to the uneven distribution of qualified care workers throughout the country. The main objective of

the study is, therefore, to investigate nurse migration and the career development of nurses in Indonesia. The specific objectives of the study are:

1. To analyse factors related to nurse migration in Indonesia
2. To analyse factors related to nurses' career development

The study utilised both a quantitative and qualitative approach in data collection. A quantitative approach was used to collect data from 313 samples of nursing school graduates using a semi-structured questionnaire covering information on educational history, family background, work history, current working condition, and internal and international migration experiences.

Interviews were conducted from September to December 2018. The respondents in the qualitative data collection were nursing school directors and lecturers, and related government officials of the Ministry of Manpower and the National Board of Placement and Protection on Indonesian Workers (*Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia*/BNP2TKI). Based on Indonesia Presidential Decree, No. 90 2019, the BNP2TKI was renamed/replaced to the Agency of Placement and Protection of Indonesian Migrant Workers (*Badan Perlindungan Pekerja Migran Indonesia/BP2MI*). The information was collected in the interview using an in-depth interview guide covering issues related to the recruitment system for Indonesian nurses working abroad and their protection and on the nursing school system in Indonesia.

a) Sampling

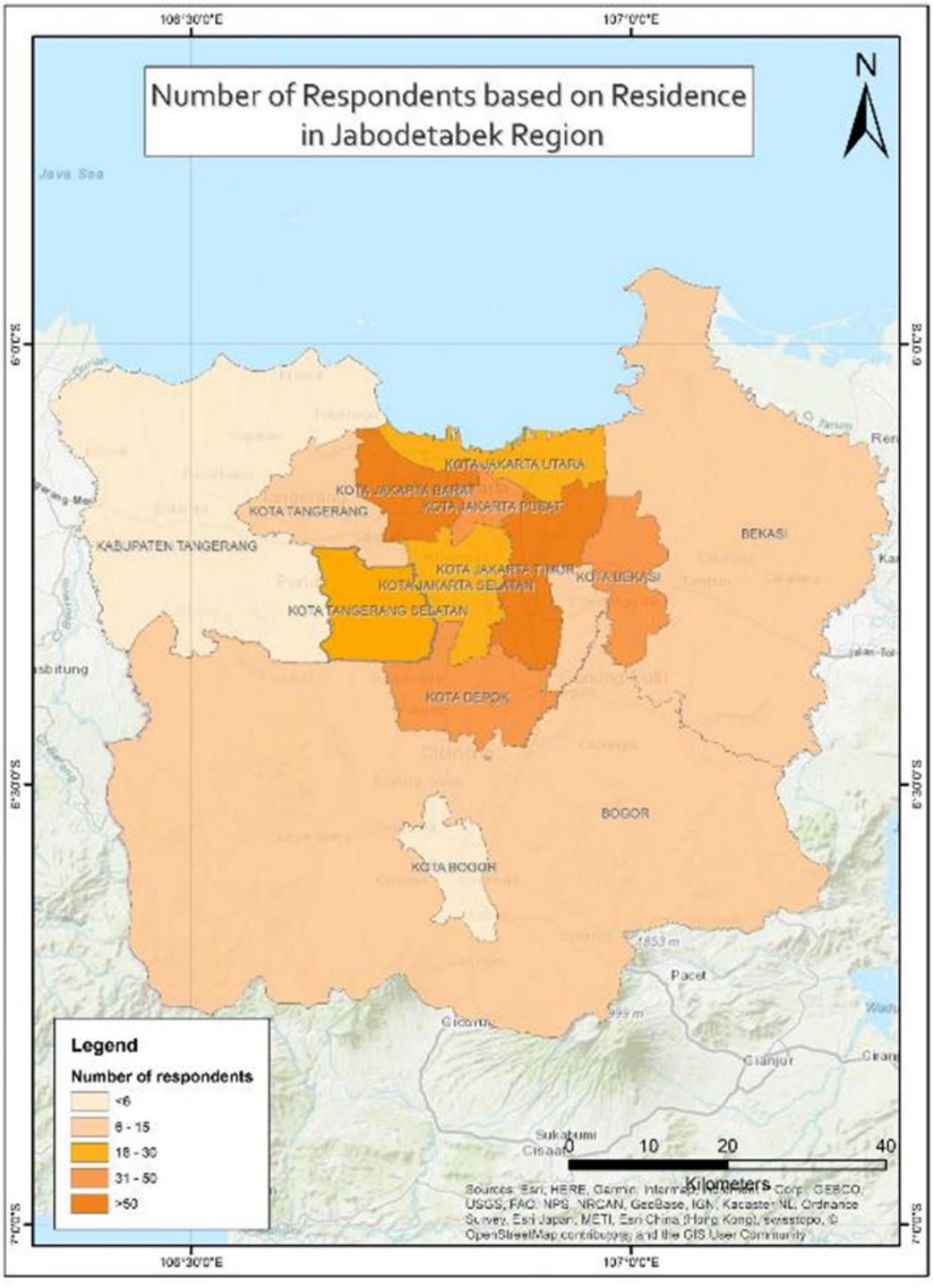
Five nursing schools were selected as the schools' sampling base, and these schools provided data on the graduates and their working places. These schools consist of three government schools and two private schools. Amongst the government schools, two schools are under the management of the Ministry of Health and one under the management of the Ministry of Research, Technology and Higher Education. For the two private schools, one is under the management of *Yayasan Pendidikan Kesehatan Carolus* (Carolus Health Education Foundation) and another one is under the management of *Yayasan Kesehatan PGI Cikini* (Cikini Indonesian Church Health Foundation). The information on these five nursing schools can be seen in Table 3.1. The nurses graduated, reside, and work in the hospitals located in DKI Jakarta and the surrounding areas (Jabodetabek: Jakarta-Bogor-Depok-Tangerang-Bekasi; see Figure 3.1 and 3.2).

Table 3.1: Information About the Nursing School Samples

Nursing school samples	Established year	Type	Location	Study programme
1. School Sample 1	2001	Government	Jakarta	Nursing (Diploma III) Midwifery (Diploma III) Dental nursing (Diploma III) Prosthetic orthotics (Diploma IV)
2. School Sample 2	2001	Government	Bekasi, Jawa Barat	Nursing (Diploma III) Ners (profession) Midwifery (Diploma III) Midwifery (Profession) Midwifery (DIV) Medical laboratory techniques (Diploma III) Medical laboratory techniques (Diploma IV) Physiotherapy (Diploma IV)
3. School Sample 3	1947	Private	Jakarta	Midwifery (Diploma III) Science of nutrition (Bachelor) Nursing (Bachelor) Nursing (Master) Ners (Profession)
4. School Sample 4	1969	Private	Jakarta	Nursing (Diploma III)
5. School Sample 5	1985	Government	Depok, Jawa Barat	Nursing (Bachelor) Nursing (Master) Nursing (Doctoral) Ners (Profession) - Nursing Leadership and Management - Medical Surgical Nursing - Maternity Nursing - Paediatric Nursing - Mental Health Nursing - Community Health Nursing

Source: Information is gathered from nursing school samples.

Figure 3.1: Number of Respondents Based on Residence in Jabodetabek Region



Source: For basic map: Esri, HERE, Garmin, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, GeoBASE, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hongkong), swisstopo,
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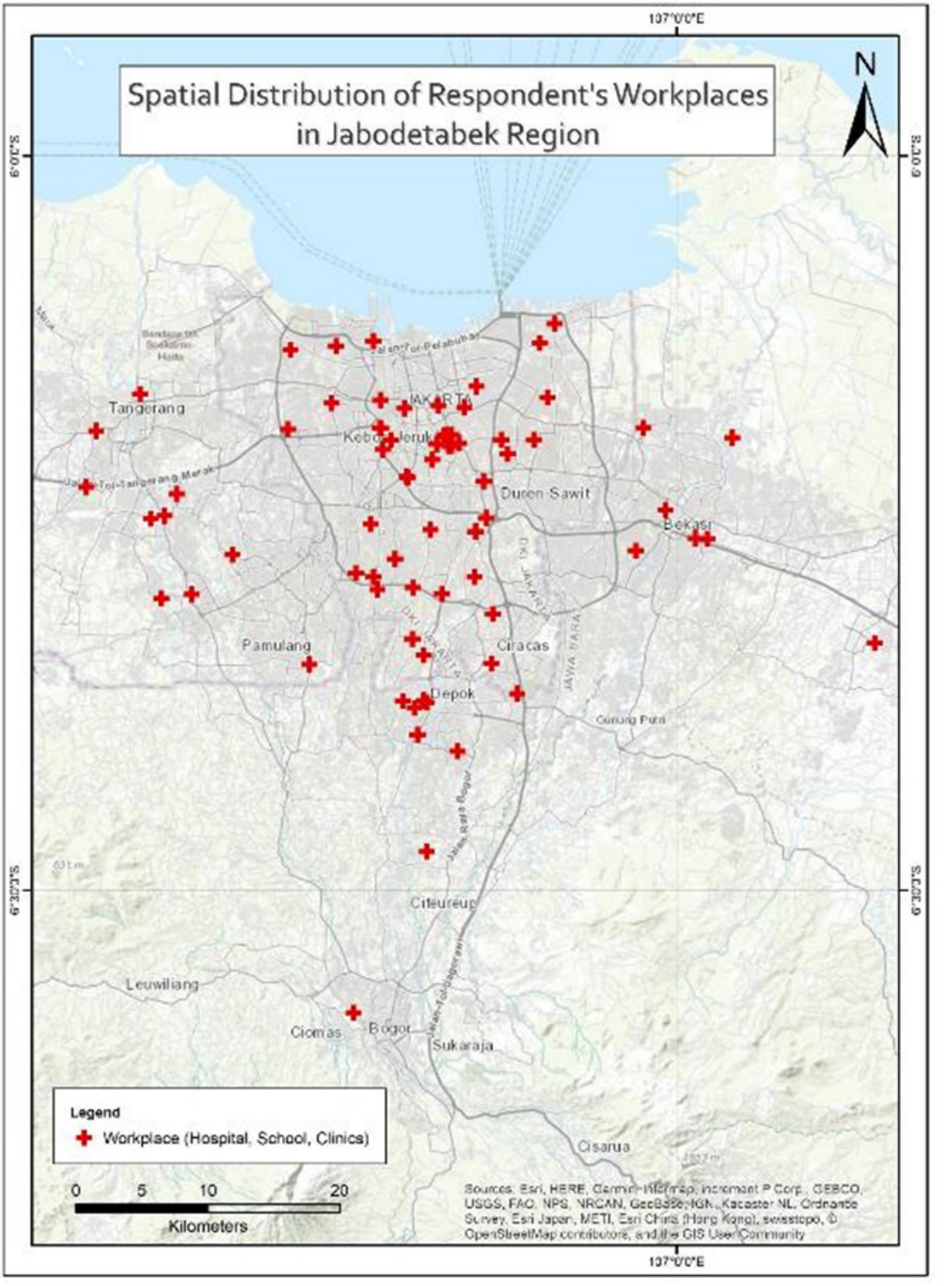
Respondents' place of residence in PPK-LIPI, IDEA-JETRO, ERIA Survey (2018).

Figure 3.2: Spatial Distribution of Respondents' Workplaces in Jabodetabek Region



Source: For Basic map: Esri, HERE, Garmin, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, Geo-BASE, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hongkong), swisstopo,
© OpenStreetMap contributors, and the GIS User Community.
Respondents' working place in PPK-LIPI, IDEA-JETRO, ERIA Survey (2018).

To find the respondents for the study, a list of nursing school graduates and their current working places was developed based on information provided by five nursing schools. This is the list of the prospective respondents of the study. The nurse samples in the study were selected based on a purposive method (interviews were carried out with the nurses that we could contact and who agreed to be interviewed/participate in the study). Since not all nursing school graduates could be traced based on these procedures, a snowball sampling method was applied to find the potential respondents. Before the interviews, the interviewers contacted the prospective respondents by phone, WhatsApp, email, and other forms of communication to arrange the interview place and time. Finally, 313 respondents were enrolled as the respondents of this study. Their attributes are the following:

- 36 male respondents.
- 10 respondents started working in 2017, and they are not included in the analysis since they are just started work and were considered to have less working experience.
- 11 respondents had experience of working abroad (seven females and four males).
- seven respondents were currently working abroad (four females and three males).
- one respondent had experience of working abroad but had stopped working currently (female, stopped working in Indonesia in 2018).
- Female respondents who were currently working in Indonesia and had work experience of more than two years but did not have experience of working abroad totalled 255 respondents.
- Male respondents who were currently working in Indonesia and had work experience of more than two years but no experience working abroad totalled 29 respondents.

Although the study is entitled 'International Migration of Indonesian Nurse', the analysis also covers nurse internal migration, since this will also have an impact on their career development.

2. Current situation of Indonesian nurses

Indonesian Law No. 36/2009 on Health states that a health provider constitutes anybody devoting his/her life to the health sector and having knowledge and/or skills obtained through education on health or any certain skill that requires authorisation to carry out health services (Article 1 paragraph 6). Nurses are considered as health providers who carry out nursing activities that are an integral part of health services.[1] The recognition of nurses as a group of health professionals has been formally declared, Government Regulation No. 32/1996 states that nurses are one of six groups of health professions in Indonesia. This is strengthened by Indonesian Law No. 38/2014 on Nursing, which that declares nursing services are a form of professional services that is based on nursing knowledge for serving individual persons, families, groups, or communities whether they are unhealthy or healthy (article 1, paragraph 3). Nursing services are delivered by nurses who have graduated from higher education in nursing in Indonesia or overseas as recognised by the government according to existing laws and regulations (article 1, paragraph 2 and paragraph 4).

In conducting their duties, nurses have to increase their skills and capabilities in order to develop their careers. The enhancement of skills and capabilities could be managed by an expansion of formal education or engaging in various courses that are relevant to their tasks as health providers. Courses can be undertaken as on-the-job training or outside the workplace. All the efforts facilitate them to upgrade their skills and capabilities in order to deliver adequate health services to those who are in need.

This part discusses the current situation of Indonesian nurses in three sections. The first section discusses government policies on the career development of Indonesian nurses. The second section focuses on the nursing education system, and the last section discusses the current number and distribution of Indonesian nurses. The analysis is based on available secondary data and is expected to present a general description of the nursing situation in Indonesia.

[1] In the document 'Development Planning of Health Provider 2011-2025", there are 13 occupations that are considered as health providers. These are medical specialist, general practitioner, dentist, nurse, midwife, dental nurse, pharmacist, assistant to pharmacist, sanitarian, nutritionist, community health personnel, therapist, and medical technique personnel.

2.1. Policy related to nurses' career development

Someone who intends to carry out a job in nursing has to undertake nursing education. After the completion of their nursing education, they are allowed to commence their nursing career in any type of health service institution. The Indonesian government has been managing the profession and career development of nurses by launching Indonesian Law No. 38/2014 on Nursing. The act covers the regulation of all aspects of nursing, including the education levels and skills that have to be possessed by the nurses, the services they deliver to those who are in need, and their code of conduct, and promotes efforts to enhance nursing capabilities. The management of nursing services by the government aims to improve the quality of nurses and nursing services, to provide protection and legal certainty for nurses and their clients, and to improve the level of community health (article 3).

According to Law No. 38/2014, nursing encompasses two categories, namely profession nurses and vocational nurses. The categorisation of nurses is in line with the level of education they have attained. Profession nurses are a group of nurses whose degrees are a bachelor, master, or doctor in nursing education, while vocational nurse is a category for those who attended a vocational college/school for nursing. Profession nurses also include two groups; 'nurse' and 'specialist nurse' (article 4). 'Nurse' refers to those who have completed higher education (university level) in nursing, as stated in the explanatory document of Law No. 38/2014. 'Specialist nurse' refers to those who have undertaken specialist education in nursing, for example paediatric and geriatric nursing.

Similar to education, the career development of nurses is also regulated by the government. It starts from satisfying the requirements that must be met by nurses before they commence nursing practice. Nursing school graduates who intend to carry out nursing services must be registered, proven by *Surat Tanda Registrasi* (STR; Letter of Registration). According to the Regulation of Ministry of Health of Republic of Indonesia No. 1796/Menkes/Per/VIII/2011 on Health Provider Registration (article 2), some prerequisites should be fulfilled by nursing school graduates to obtain the STR, such as holding a certificate of competence, besides a nursing school/college diploma. The possession of a certificate of competence is particularly compulsory for nursing school graduates from 2012 and onward. Those who graduated from nursing school before 2012 are not required to take a competence test in order to obtain an STR. Graduates from 2012 and onwards may possess a certificate of competence if he/she passes the

competence examination based on her/his level of education. A certificate of competence is issued by the Ministry of Education and Culture (formerly Ministry of Research and Higher Education), while an STR is issued by the Council of Health Provider of Indonesia (*Majelis Tenaga Kesehatan Indonesia;* MTKI). The council was established by the Ministry of Health and consists of representatives of the Ministry of Health, profession organisations related to health providers, and schools of health. The STR is effective for five years and should be re-registered in every five years.

As mentioned previously, nurses have to advance their skills and capabilities over time. This can be done through various efforts, such as undertaking training, courses, and non-formal education on skills related to their chores. Law No. 38/2014 on Nursing mentions that owners or management teams of health facilities that employ nurses have to facilitate them to undergo continuous education (article 53, paragraph 4). This aims to enhance their skills and capabilities in order to provide optimal services to patients or clients.

In Indonesia, nurses are classified into four categories. These are clinical nurses, management nurses, teaching nurses, and researcher nurses.[2] Clinical nurses directly provide nursing services to clients, such as individuals, families, groups, and communities. Clinical nurse work in health facilities, such as hospitals and clinics, and other facilities in the community as necessary. Management nurses manage nursing services in health facilities and range from front line managers and middle managers to top managers. Teaching nurses are those who work as lecturers at nursing schools (formal education) or trainers for non-formal nurse education. Lastly, researcher nurses carry out research on nursing and health issues, for example research on effective nursing practices for patients with special needs. Each nurse category consists of five levels, such as clinical nurse I, clinical nurse II, clinical nurse III, clinical nurse IV, and clinical nurse V according to the skill levels. Clinical nurses may shift to manager nurse, teaching nurse, or research nurse as long as they meet the requirements.

[2] http://hukor.kemkes.go.id/uploads/produk_hukum/PMK_No._40_ttg_Pengembangan_Jenjang_Karir_Profesional_Perawat_Klinis_.pdf.

2.2. Nursing education systems

Nursing education in Indonesia was initiated during the pre-independence period. As time has gone on, nursing education has been adjusted several times in accordance with the changing and expanding demand for nursing services, aiming to supply qualified nurses who are able to provide optimal services for clients, which in turn allows the government to achieve their health development goals.

Nursing education used to be recognised as secondary education, specifically the senior high school level. However, nowadays it is categorised as a higher level of education (tertiary education). Indonesian Law No. 20/2003 on National Education System states that a higher education level is an education level following senior and junior high school (article 19 paragraph 1). The higher education level is convened by tertiary education institutions, which have several categories, such as 'academy', 'polytechnic', 'higher school', 'institute', and 'university'.

Referring to Law No. 20/2003 on National Education System and Law No. 38/2014 on Nursing, nursing education comprises three various types of education, namely vocational education, academic education, and professional education. Further explanation of each type of education is as follow:

1. Vocational education is known as D III (Diploma III) and D IV (Diploma IV) on nursing. Vocational education focuses more on applied skills to create graduates who have mastered practical skills. D III is a three-year education in nursing. After completion, graduates receive the degree of Amd. Kep., an abbreviation of *Ahli Madya Keperawatan* (middle expert in nursing). D III graduates are eligible to title themselves with 'Amd. Kep' following their names. D IV requires four years to complete the course and a graduate gets the degree of S. ST., an acronym for *Sarjana Sains Terapan* (Bachelor of Applied Science). Graduates of the D IV education are entitled to use 'S.ST' following their names.
2. Academic education covers the three educational levels of bachelor, magister, and PhD on nursing, which in Indonesia are known as S1, S2, and S3. Those who complete a bachelor course receive the title of S. Kep. (*Sarjana Keperawatan*; Bachelor of Nursing) and are allowed to use the title 'S. Kep.' after their names. A bachelor programme can be accomplished in four years, while completing a magister programme needs another two years. The title of a magister for a nursing

graduate is M. Kep. (*Magister Keperawatan*; Magister of Nursing). For these graduates, 'M. Kep.' can be added after their names.

3. Professional education refers to any type of further nursing education that can be undertaken by graduates of bachelor course and magister levels. Professional education consists of two types of education. One is the nurse profession, which can be undertaken by those who have accomplished four years of education in a bachelor course. This education course requires one year to complete and is designed to provide further education aimed at creating professional nurses. Those who complete this education receive a title of *Ns.* (Ners), which can be used before his/her name. Hence, a professional nursing education graduate is entitled to write 'Ns.' before his/her name and 'S. Kep' after his/her name. Another type is advanced education for nurse specialists. This type of education is one year of further training after completion of a master's degree in nursing. Recently, there are five fields available for nurse specialists, namely community nursing, maternity, surgery, psychiatry, and paediatrics.

Nursing education is managed by nursing schools owned by government and private institutions. On the government side, the schools are run under the coordination of two ministries, namely the Ministry of Education and Culture and the Ministry of Health. Nursing schools under the Ministry of Education and Culture are operated by universities in many provinces in Indonesia. Some universities have a faculty of nursing, and some place the nursing school under the faculty of medicine or the faculty of public health in their organisation structures. Besides these, there are other facilities that provide nursing education under the jurisdiction of the Ministry of Health. Polytechnics of health can be found in several provinces. Data show that in 2017, there were 70 Diploma III programmes operated by the Ministry of Health in Indonesia. The total number of students was 21,017 (Ministry of Health, 2018), and the number is increasing. In 2015, for instance, there were 17,779 students enrolled in existing nursing schools. The number increased to 19,058 and 21,017 in 2016 and 2017, respectively. The private sector also takes part in carrying out nursing education. Like government institutions, private nursing schools are also established under universities, academies, and polytechnics.

After completing nursing education at all levels (D III, D IV, bachelor, magister, and PhD), one is required to take a competence test before practicing nursing services. The competence test is a written examination, and the questions are based on the candidate's level of education. The test is held under the collaboration of many stakeholders, namely

the Ministry of Education and Culture, the Indonesian National Nurse Association, and the Indonesian Nursing Education Association. Those who pass the test are eligible to receive a certificate of competence. The certificate is one of the requirements to receive an STR, which is issued by the MTKI. An STR is required to apply for jobs in health facilities. The STR must be renewed in every five years in order for nurses to maintain their jobs (through an interview with a selected nursing school manager).

Nursing education never ends, even after the completion of all formal education programmes. Law No. 38/2014 on Nursing mentions the development of nurse capability. Article 53 paragraph 4 points out that the management of health facilities where nurses work has to facilitate them to advance their competence through formal and non-formal education. This means that nurses have to continuously learn during their employment period. It is understandable, therefore, that some hospitals employ nurses with a lower level of education, for example D III, and facilitate them to increase their education. Indeed, some hospitals offer financial assistance or scholarships for nurses to enhance their education.

There is a tendency for health facilities, particularly some hospitals in big cities, to recruit nurses with higher levels of education. An interview with a nurse who is a lecturer at a nursing school owned by a private hospital in Jakarta confirmed this argument. Recently, some hospitals only recruit nurses who hold bachelor's degrees and have graduated from professional education. Those who only graduate with a Diploma III level of nursing are encouraged to advance their education. Such a requirement is not likely to be applied in small cities and remote areas. Since the number of nurses with such a level of education is low and such nurses are unevenly distributed, many hospitals in small cities still employ nurses who are Diploma III graduates.

2.3. Indonesian Nurses: Number, ratio, and distribution

Data launched by the Ministry of Health of the Republic of Indonesia shows that in 2016, the total number of health facilities, such as *Puskesmas* (*Pusat Kesehatan Masyarakat;* Primary Healthcare Centres) and public and private hospitals, was 15,263. There were 1,000,780 health providers working at the facilities, comprised of various health professions. Of this number, 60,228 were medical specialists, medical doctors (general practitioners), dentists, midwives, nurses, and pharmacists. The data show that nurses outnumbered every category of medical personnel, and the total figure was 296,876

(41.28%). In 2017 the number of nurses increased by 16.3%, and there were 345,276 nurses in Indonesia (Ministry of Health, 2017).

As mentioned previously, the Indonesian government targeted a nurse-to-population ratio of is 180:100,000 for the year 2019. The target is mentioned in the 'Decision of Coordinating Minister for People Welfare No. 54/2013 on Development Planning of Health Provider in 2011-2015'. However, it is difficult to achieve the target. Indeed, in 2014 the target of 158:100,000 was not accomplished. In 2016, the nurse-to-population ratio was 113:100,000, which far below the 2014 target. Nevertheless, some provinces reached the goal and attained a ratio exceeding the target. These provinces were the Jakarta Capital Region (221:100,000), East Kalimantan (202:100,000), and Bangka Belitung Island (202:100,000). On the other hand, Lampung, West Java, and Banten were the three provinces with the lowest ratios in 2016. The ratios were 48:100,000, 68:100,000, and 72:100,000 for the three provinces, respectively (Ministry of Health, 2017). Based on this fact, in the coming years, Indonesia will still need more nurses, and they should be distributed evenly to meet the needs of the whole population in all parts of the country.

The Government of Indonesia has attempted to produce more nurses to meet the need by collaborating with private educational institutions. Many public nursing schools have been established by the government under the management of the Ministry of Education and Culture and the Ministry of Health in all provinces in Indonesia. Nursing schools under the jurisdiction of the Ministry of Health, i.e. polytechnic of health all over Indonesia, created 6,835 nurses with Diploma III certificates in 2015. The number of graduates at the same level in 2016 and 2017 were 6,257 and 5,756, respectively. In 2017 polytechnics of health also created 1,911 nurses with Diploma IV certificates. Unfortunately, it is difficult to obtain data on the number of graduates from nursing schools under the jurisdiction of the Ministry of Education and Culture, which have various faculties at public universities and private nursing schools. All established nursing schools under the Ministry of Education and Culture have trained large numbers of nurses to provide nursing services, compared with private institutions.

2.4. The needs of nursing services

Nurses work at various types of health facilities, ranging from primary health centres at the sub-district level to hospitals, which provide health services at the district and province levels. Some nurses work at primary health centres in remote areas, including the hinterland and small islands at the Indonesian sea that border areas with neighbouring countries. During 2017, about 29.12% of all health personnel who worked at primary health centres in Indonesia were nurses. The percentage of nurses amongst the entire health personnel who were employed at hospitals was 33.53%. Moreover, nurses comprised 31.67% of all health personnel working in remote areas (Ministry of Health, 2018).

Apart from those working at primary health centres and hospitals as mentioned above, there are also many nurses who were recruited to work in remote areas under certain programmes. The programmes specifically aim to provide health services for people living in these areas. One of the programmes is *Nusantara Sehat* (Healthy Nusantara), which deploys health personnel comprising medical doctors, nurses, and midwives, to remote areas, including small islands in many parts of Indonesia. In 2017 the number of nurses employed under the programme was 666, and these nurses worked in many remote areas of Indonesia.

As mentioned in the previous section, the nurse-to-population ratio in Indonesia is still low. However, at some primary health centres, the number of nurses is relatively sufficient. Data show that 66.6% of primary health centres have more nurses than required (Ministry of Health, 2018). Moreover, about 7.2% of primary health centres have an adequate number of such health personnel, while the rest (26.2%) have an insufficient number of nurses. As the distribution of Indonesian nurses is still uneven, the primary health centres with sufficient numbers of nurses are probably located in particular provinces, such as the Jakarta Capital Region, East Kalimantan, and Bangka Belitung Island. For the Jakarta Capital Region, almost all of its parts are categorised as urban areas. This implies that the nurses are working in urban areas. Therefore, it can be said that a large number of nurses are providing health services in these areas. In contrast, the primary health centres that still lack nurses are located in other provinces in Indonesia, including Lampung, West Java, and Banten. This condition again shows that distributing the nurses is still a problem that should be overcome by the Indonesian government.

Nursing services are related not only to curative healthcare facilities but also to other services, for example elderly care. Considering the increasing number of elderly people, more nurses, especially those with adequate skills in nursing and caring for older people, are needed. As a consequence, the government, in particular, should prioritise attempts to produce skilled nurses, particularly for elderly care.

3. Indonesian nurse migration: Survey results

Internal and international nurse migration is an important issue to be explored in Indonesia. Buchan et al. (2003) explain that nurses are considered as a key group of 'knowledge workers' in labour migration in efforts to solve skill shortages in one area by recruiting from other areas that have a surplus supply of nurses. In the context of internal migration, nurses' mobility in Indonesia is an important issue due to the uneven distribution of the population and nurses throughout the country.

As previously pointed out, nursing is not a major occupation when considering Indonesian labour migration to work abroad. However, international nurse migration to work abroad will become an important issue since many countries in Asia are experiencing nurse workforce shortages. Peng (2017: 4) stated that currently, the Philippines is the main sending country for care workers (nurses and care givers) to Japan. Meanwhile, Indonesia is the most important sending country for care workers to Taiwan, and in 2015, 79% of foreign care workers working in Taiwan were from Indonesia

Indonesia has also been considered as a country with a surplus nursing workforce (Efendi et al., 2013). This might be one reason for the demand from other countries in the world. Meanwhile, nurse utilisation in Indonesia is still below the government target ratio. Therefore, the underutilisation of the nursing workforce in the country will become a push factor for Indonesia nurse migration abroad. This creates a dilemma. On one hand, the underutilisation of the nursing workforce in Indonesia results in a nurse-to-population ratio that is lower than the government target ratio, while Indonesia's nursing workforce needs will continue to increase due to the ageing population in the future. On the other hand, the employment opportunities opening for the nursing workforce in other countries will become a pull factor for nurse migration from Indonesia to work abroad. This section will analyse the characteristics of nurse respondents, the factors related to nurse migration in Indonesia, and the importance of employment experience abroad for nurses' career development based on the data collected in the study.

3.1. Demographic characteristics of the respondents

This section discusses the demographic characteristics of the respondents. The respondents are split into two groups, migrants and non-migrants. Migrants refer to those whose places of residence during the study were different from their places of birth, also called 'lifetime migrants'. On the other hand, non-migrants are respondents whose places of residence are the same as their places of birth.

Almost two-thirds of the respondents are migrants as their place of residence differed from their place of birth. We did not ask the time of migration from their place of birth to the current place of residence, but the reason for migration was asked. We define the migrants who moved from their places of births to receive nursing education as 'migrants for education reasons'. Such migrants can be categorised into two groups. The first category comprises respondents who moved to Jakarta when they were enrolled in nursing schools. The second is those who graduated from a lower level of nursing education in places other than Jakarta, and then received further education in nursing schools in Jakarta. This includes, for example, someone who attained a Diploma III certificate from a nursing school in Medan (North Sumatra), and afterwards accomplished a bachelor's degree and the nurse profession in a sampled nursing school located in Jakarta. The study reveals that 32% of the respondents were 'migrants for education reasons', which means that they moved to Jakarta to enrol at selected nursing schools.

More than three-fourths (77.2%) of respondents commenced their first job in Jakarta, and all were no longer working at the health facilities where they started. As much as 83.1% of respondents answered that they were working in Jakarta at the time of the survey. This means that 5.6% of them moved to the capital city during their work life. This finding can suggest that more nurses are attracted by Jakarta as their working place.

Table 3.2: Demographic Characteristics of Respondents by Migration Status

Demographic characteristics	Migrant	Non-migrant	Migrant + Non-migrant
Age			
20–24	15	17	32
25–29	76	37	113
30–34	34	5	39
35–39	26	7	33
40–44	32	4	36
45–49	19	2	21
50–54	21	4	25
55–59	7	2	9
60–64	4	0	4
65 and older	1	0	1
N	235	78	313
Sex			
Male	28	8	36
Female	207	70	277
N	235	78	313
Marital status			
Single	76	41	117
Married	157	36	193
Divorce	2	1	3
N	235	78	312
Education			
Diploma III	84	48	132
Bachelor	8	1	9
Nurse profession	132	28	160
Nurse specialist	6	1	7
Others*	5	0	5
N	235	78	313
Ethnicity			
Javanese	102	40	142
Sundanese	15	7	22
Betawinese	9	17	26
Bataknese	44	10	54

Minangnese	11	1	12
Balinese	5	0	5
Flores	22	2	24
Others	27	1	28
N	**235**	**78**	**313**
Religion			
Islam	111	63	174
Catholic	62	5	67
Protestant	59	10	69
Hindu	3	0	3
N	**235**	**78**	**313**
Current place of residence (province)			
Jakarta Special Capital Region	103	48	151
West Java	98	21	119
Banten	22	9	31
Papua	1	0	1
East Nusa Tenggara	1	0	1
East Kalimantan	1	0	1
North Sumatra	1	0	1
Abroad	8	0	8
N	**235**	**78**	**313**
Current workplace			
Jakarta Special Capital Region	187	68	255
West Java	25	4	29
Banten	9	3	12
Papua	2	0	2
East Nusa Tenggara	2	0	2
Abroad	7	0	7
N	**232**	**75**	**307****
Occupation of father			
Armed forces	23	6	29
Manager	5	3	8
Professional	75	22	97
Technician and associated professional	12	5	17
Clerical support worker	15	8	23

Service and sales worker	46	15	61
Skilled agricultural, forestry, and fishery worker	38	1	39
Craft and related trade worker	4	4	8
Plant and machine operator and assembler	14	9	23
Elementary occupation	2	5	7
No answer	1	0	1
N	235	78	313
Occupation of mother			
Housewife	131	55	186
Professional	61	12	73
Clerical support worker	2	1	3
Service and sales worker	23	6	29
Skilled agricultural, forestry, and fishery worker	16	1	17
Craft and related trade worker	1	0	1
Plant and machine operator and assembler	1	2	3
No answer	0	1	1
N	235	78	313

Note: * Others refer to respondents, particularly those who are of older ages, who graduate nursing education at the senior high school level. Previously, there was a vocational school in nursing at the level of senior high school. The school is not categorised as higher education level. One respondent who graduated junior high school was able to continue his/her education.
**Six respondents were not working currently since they entered further education.
Source: PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

The respondents were dominated by those of prime working age (25–54 years). The data in Table 3.2 show that 267 respondents (more than 80%) are in this age group. Amongst this group, the highest number was those aged 25–29 years (36%). The mean age of the respondents was 34.6 years and the median age was 30 years. In terms of migration status, a larger number of non-migrants than migrants is seen only for the 20–24 year age group. In other age groups, migrants outnumbered non-migrants.

The study finds that almost two-thirds of the respondents are married. Comparing migrant and non-migrant respondents, the percentage of those who are single is far higher amongst non-migrants. This is because the proportion of non-migrant respondents in the youngest age group (20–24 year) is more than three times higher than the proportion for migrants. As there are more non-migrant respondents in this age group, it is reasonable that more of them are single.

The data in Table 3.2 show the educational attainment of the respondents. It can be said that the respondents have obtained sufficient knowledge of nursing since more than half of all the respondents had 'nurse profession' certificates that can be achieved after the completion of one more year of education after graduating from a bachelor's degree in nursing. Less than half were Diploma III graduates, the minimum educational requirement for nurses in Indonesia. There is an interesting phenomenon when comparing migrant and non-migrant respondents in this aspect. The percentage of migrants with a higher level of nursing education (bachelor and over) is far higher than non-migrants (two-thirds and one-third, respectively). On the contrary, the proportion of respondents with a lower level of education (Diploma III) is far higher amongst non-migrants than migrants.

The survey also asked about the respondents about their parents' occupation. The respondents were requested to answer about their parents' occupation unless they had passed away. The study reveals that the category with the highest percentage of responses for the fathers' occupation was professional. This could be found both for migrant and non-migrant respondents. The category with the second-highest percentage for the fathers' occupation was service and sales worker. For the third-highest category, there was a difference between migrants and non-migrants. For migrant respondents, the category was skilled agricultural, forestry, and fishery worker, while for non-migrants it was plant and machine operator and assembler. The data can be interpreted as that some migrant respondents come from rural areas where jobs in agriculture, forestry, and fishery are still dominant. For the occupations of the respondents' mothers, the study reveals typical job segregation between men and women. More than half of both the migrants' and non-migrants' mothers were housewives, which is a typical women's job in society. The category with the second-highest percentage for the respondents' mothers' occupation was professional. This was particularly higher amongst migrants than non-migrant respondents.

In the study, the respondents were questioned on their ability to speak foreign languages. The results show that a majority of respondents answered that they were able to speak some foreign languages. These foreign languages included English, Japanese, Arabic, French, Germany, Dutch, Korean, Mandarin, and Taiwanese. English is a foreign language that is taught since elementary school up to the university level in Indonesia. Other languages are taught in some schools, especially at the senior-high level. Some nursing schools teach Japanese language due to the demand from the country for Indonesian nurses and caregivers for the elderly (based on an interview with one of the selected nursing school managers). According to our in-depth interviews with respondents, their foreign language abilities were only passive, in the sense they are good at listening and reading. They have limited capability in speaking, which in turn causes difficulties for them in working overseas. Regarding this situation, foreign language training is absolutely needed for those who intend to work overseas.

3.2. Indonesian nurse migration to work abroad

a) Indonesian nurses' experiences of working abroad

According to the survey, there were 19 nurse respondents who had experienced working abroad, including seven that were still working abroad. They had worked in Japan (eight nurses) and Gulf countries (Saudi Arabia, Kuwait, United Arab Emirates: five nurses), and the rest had worked in several countries in Asia, Africa, and Europe. According to the 19 nurse respondents, those who had worked in Japan started in 2008, while those who had worked in Saudi Arabia started in 1997. The opportunity for Indonesian nurses to work in Japan was first provided by the Indonesia-Japan Economic Partnership Agreement (IJEPA), which was agreed upon by Indonesia and Japan in 2008. The IJEPA has two programmes for such nurses: the nurse candidate programme and the caregiver candidate programme. All eight respondents who had worked in Japan were IJEPA candidates. Only one was a nurse candidate and the rest were candidate caregivers, and all of them started work in Japan in 2008 as the first batch of the IJEPA programme. One respondent who started to work in Japan as a nurse candidate under the IJEPA said she was first assigned just the jobs of nurse assistants until she passed the national exam and became a registered nurse in Japan. Her career was consistent with the procedure adopted in the IJEPA.

Some reasons that the respondents stated for working abroad were:

- To get experience working abroad
- Better career advancement
- Higher salary
- Training programme
- Continue to further education
- Following a senior friend

b) Indonesian nurses' intention to work abroad

Several factors that may affect the respondents' intention to work abroad are analysed in this study. The analysis is based on respondents who had worked for at least two years in Indonesia and did not have any experience of working abroad, comprising 255 female respondents and 29 male respondents. The exclusion of respondents who had less than two years of work experience in this analysis is based on the assumption that they would not have had enough experience working as a nurse to consider their further career development.

There was almost no difference in the intention to work between the female and male nurses. Amongst the female nurses, 73 respondents (about 28.6%) stated that they intended to work abroad, while amongst the male respondents, eight respondents (about 27.6%) said they had an intention to work abroad. So, there was almost no difference in the intention to work abroad amongst the female and male nurses.

The existing literature (Li et al., 2014: 315; Nair and Webster, 2012: 158–159) argue that the underlying reasons for the international migration of nurses are complicated. According to Li et al. (2014), nurses are pushed by their home countries and pulled by recipient countries to migrate. In the home country, substandard conditions or circumstances encourage nurses to leave their country and, thus, represent the push factors. The conditions of the recipient countries represent a pull factor as they attract and facilitate the movement of nurses to that country. The push factors include low wage compensation, limited career opportunities, limited educational opportunities, lack of resources to support work, lack of social and/or retirement benefits, and dangerous working conditions. The several pull factors include the availability of job opportunities for professionals, opportunities for career advancement and personal development, the recognition of professional expertise, a professional work environment, attractive salaries, and social and retirement benefits. The economic reason of getting a better/higher salary and incentives is generally regarded

as an important reason because it is commonly known that the salary and wages when working abroad are higher than working in the country. However, as shown in Table 3.3, the reasons for the intention to work abroad amongst Indonesian nurses are mainly for getting more experience and skill improvement and for better career advancement. For the questions about the destination countries, the survey data show that the highest percentage (34%) of nurses who had an intention to work abroad preferred Japan as their destination country. This could be related to the wide publicity about the IJEPA programme, which has been well publicised by the National Board on Placement and Protection of Indonesia Migrant Labour (BNP2TKI). Other important destination countries are Australia (13.8%), the United States (13.8%), and the Netherlands (11.5%). Amongst nurses who do not have any experience working abroad, most of them are not interested in working abroad mainly due to family constraints.

Table 3.3: Distribution of Female Nurses with no Experience Working Abroad by Reason for Intention to Work Abroad and No Intention to Work Abroad

Reason for intention to work abroad	N
Expected to get experience by working abroad	41
Higher salary and incentives	7
To improve nursing skills	4
Better career advancement	21
Number of cases	73

Reason for no intention to work abroad	N
Not interested to work abroad	93
Limited information on working opportunity and condition abroad	11
Have already worked as civil servant	11
Family does not approve of working abroad	48
Lack of working experience	4
Language constraint	1
Others	14
Number of cases	182

Source: PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

Because of the small number of male respondents, we focused on female respondents for the detailed analysis. In the analysis, factors related to nurses' intention to work abroad are classified into three groups: (1) individual characteristics, (2) satisfaction at work as a proxy for factors preventing female nurses from working abroad, and (3) problems at work as a proxy for push factors in the nurses' intention to work abroad.

Table 3.4 shows the possible factors of the female respondents' individual characteristics that may affect their intention to work abroad, i.e. age, marital status, and education. The data indicate that younger nurses (below 35 years) have a greater intention to work abroad compared to older nurses. Of the respondents, 28.6% said they intend to work abroad.

Table 3.4: Female Nurse Individual Characteristics by Intention to Work Abroad (percentage)

Nurse individual characteristics	Intention to work abroad		
	Yes	No	Total
Age group			
20–24	10	10	20
25–29	41	56	97
30–34	11	18	29
35–39	6	22	28
40–44	4	28	32
45–49	0	16	16
50 years and over	1	32	33
Total	73	182	255
P-value			*0.001***
Marital status			
Single	43	45	34.5
Married	30	134	64.3
Divorce	0	3	1.2
Total	73	182	255
P-value			*0.001***

Final education (at nursing school)			
Diploma 3 years	36	66	102
Bachelor	1	4	5
Ners Profession	35	106	141
Ners Specialist	1	4	5
Other	0	2	2
Total	73	182	255
P-value			*0.394*

Note: P-value for Independence Test using non-parametric test (fisher test) of nurses' individual characteristic to female nurses' intention to work abroad:
Significant at: * 10%; ** 5%; *** 1%
Source: Authors' calculation on data in PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

The results suggest that respondents aged 25–29 are more likely to have an intention to work abroad. This might be related to their family status, education, and work experience. Compared with the older age group (35 years and above) the younger nurses were more likely not be married yet, and they were also more likely to have less family responsibility (children). Therefore, it is easier for them to plan to work abroad (the data showed a higher intention to work abroad amongst single nurses compared to married nurses). The older nurses might also have more work experience and stable jobs in the country compared to those in the younger group, which might prevent them from leaving their families to work abroad.

For the final education of the respondents, the results show that about 40% graduated from Diploma III education, and 55.3% graduated from the Ners Profession education. Only a few respondents had the title of 'Ners Specialist'. Respondents whose academic background was Diploma III level were more likely to have an intention to work abroad than the respondents whose backgrounds were a higher level (Table 3.4). Diploma 3 years is the lowest level in nursing education, so a higher proportion of those who intend to work abroad might be related to the expectation (amongst nurses with a Diploma 3 years education) of having the opportunity to increase their skills and knowledge by working abroad. Amongst nurses with a Ners Profession education (higher qualification), they were likely to have more secure and permanent jobs, and this prevents them from intending to work abroad. Some of them might also have been sponsored by their workplace (e.g. hospital) to obtain a Ners Profession education, which binds them to their workplaces.

In this study, problems encountered in the workplace can be regarded as a push factor for nurses in Indonesia to leave their current jobs and try to find jobs abroad. Satisfaction at work can be regarded as a potential factor that prevents female nurses from working abroad, or that holds them to their current work in the country. We conducted univariate analyses to examine the relationship between the female respondents' intention to work abroad and several items that can be categorised as 'satisfaction at work' or 'problems at work'. Amongst the factors related to satisfaction at work, only one factor, 'relation with superior', shows a significant relationship with the female nurses' intention to work abroad. This means that a good social environment at the workplace might cause nurses to stay in their current jobs. Other factors, such as salary and social status as a nurse, etc., did not show significant relationships. An important push factor in this analysis amongst 'problems at work' that showed a significant relationship with female nurses' intention to work abroad is 'work risk'. Our in-depth interviews with respondents found this to include risk/safety for women working at night, risks related to contact with patients with infectious diseases, and the use of hospital equipment. Such risks faced by nurses are common in any workplace for nurses, including overseas, but it seems the respondents were not aware that they would face the same risks even if they worked overseas and assumed developed countries would have more advanced safety and security standards for protecting nurses. This is because all of them (nurse samples in the analysis) had never worked abroad. This finding suggests that the Indonesian Government needs to provide Indonesian nurses with detailed information on the working conditions abroad so that they can make a proper decision to work or not work abroad.

Table 3.5: Independence Test Using Non-parametric Test (Fisher Test) of Satisfaction at Work and Problems at Work on Female Nurses' Intention to Work Abroad

Factors	Category	N (255)	P-value
Satisfaction at work: Factors that prevent female nurses from working abroad			
Social status as nurse	Yes	254	1.000
	No	1	
Ease of getting job	Yes	252	0.560
	No	3	
Level of pride in yourself (as a nurse)	Yes	254	1.000
	No	1	
Salaries and Incentives received	Yes	221	0.684
	No	34	

Relationship with colleagues	Yes	254	1.000
	No	1	
Relationship with superior	Yes	247	0.045**
	No	8	
Career developments, including promotions/advancement	Yes	230	0.484
	No	25	
Facilitation of training	Yes	237	0.601
	No	18	
Work situations, examples of working hours, night shifts, assignments	Yes	237	0.416
	No	18	
Problems at work: Push factors for female nurses to work abroad			
Work risk	Yes	190	0.007***
	No	65	
Limited career development opportunities	Yes	142	0.578
	No	113	
Patient-nurse ratio	Yes	207	0.111
	No	48	
Low salaries and incentives	Yes	181	0.879
	No	74	
Hospital's facilities	Yes	122	0.783
	No	133	
Poor working conditions	Yes	125	0.167
	No	130	
Work relations that are not harmonious with superiors	Yes	59	0.251
	No	196	
Work relations that are not harmonious with co-workers	Yes	54	0.735
	No	201	
Limited work competency and knowledge as nurses	Yes	93	0.887
	No	162	

Significant at: * 10%, ** 5%, *** 1%
Source: Authors' calculation on data in PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

3.3. Career development

A career is defined as the way a person experiences the sequence of jobs and activities that constitute his/her working history (Hall, 2002). Career development is an ongoing process that involves reciprocal interaction between employees and employers and is achieved in a way that the attainment and/or enhancement of individual capabilities are not restricted to a particular job, career path, or organisation (McDonald and Hite, 2005). Career development can be both formally and informally facilitated, and this is possible in or out of an organisation. Individual workers should be involved in career development in order to increase their capabilities for carrying out jobs.

As mentioned in the previous section, before initiating a career in nursing, one should have knowledge and skills in nursing services. These can be attained at nursing schools, which have several degree levels. After accomplishing the nursing education, he/she has to fulfil all the requirements needed to be a nurse at various types of health facilities. During the employment period, the person should upgrade his/her knowledge through participating in training/courses that are relevant to the job. This refers to Law No. 36/2009 on Health, which mentions that nurses are required to advance their knowledge and skills during the employment time. The advancement of knowledge and skills may support their career development in nursing.

Respondents in this study were asked four questions on efforts related to career development. They were asked whether or not they took and passed a competence examination, owned a Letter of Registration for nurses (STR), took training/courses to upgrade their nursing skills, and registered with a nurse association (see Table 3.6). Passing the competence test and owning an STR are required for working at health facilities. Participation in training/courses related to their tasks as a nurse can be an indicator of efforts to increase their capabilities, which is a factor supporting career development. Moreover, registering in a nurse association is an opportunity to obtain up-to-date information and knowledge related to nursing services.

Table 3.6: Efforts to Support Career Development

Efforts for career development	Yes	No
Taking competence examination	203	99
Ownership of Letter of Registration for nurses	296	17
Undergoing training/courses to upgrade nursing skills	305	8
Registered in nurse association	287	26

Source: PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

Table 3.6 shows that almost all the respondents have undergone all the processes and fulfil all prerequisites to be employed at their workplace. Furthermore, they have also made efforts to acquire advanced knowledge and skills related to nursing services. For a reference to interpret these results, one-third of the respondents who did not undertake a competence examination were those who graduated nursing school before 2012. It is not mandatory for them to take and pass a competence test, but they are eligible to have an STR, as mentioned previously.

The study finds that the majority of respondents have undergone training/courses to improve their nursing skills. Some training/courses are held in hospitals/health service facilities where they are working, in the form of short training/courses of one to two days. Less than 2% have undergone training abroad. Moreover, almost three-fourths of respondents were funded to participate in the training/courses by the hospitals/health services employing them. For employers, this shows an effort to have highly qualified nurses to provide prime health services for their clients. Nearly one-fourth of the respondents had undergone training/courses through self-funding. They participated in the training/courses due to the increasing demand for nurses/health service providers with updated knowledge and skills.

In this study, the respondents were asked questions related to their satisfaction in their career development. The answers for each question were classified into four categories: 'not satisfied', 'fair', 'satisfied', and 'not applicable'. Amongst the questions, 281 respondents (95.6%) stated that they were satisfied with their role to 'care for the sick people and those who need care' (see Table 3.7). The least satisfaction related to their career as nurses was for the 'salaries and incentives they received', while the second-lowest level of satisfaction was for 'career development, including promotion and

advancement'. As mentioned previously, more than 90% of respondents have undergone several efforts related to career advancement (Table 3.6). However, those who expressed that they were satisfied with their career development totalled only 155 respondents (52.7%). About one-third of respondents were averagely satisfied, while almost 10% said they were not satisfied with their career development. This study finds that 168 respondents (57%) answered that is was difficult and quite difficult to develop their careers due to limited opportunities to do so (Table 3.8). Less than half said they found no difficulties in career development. The figure may imply that career development is a problem faced only by some respondents.

Table 3.7: Satisfaction Related to Career Development

Satisfaction related to career development (n = 294)	Not satisfied	Fair	Satisfied	Not applicable
Care for sick people and those who need care	2	11	281	0
Ease of getting job	3	33	257	1
Salaries and incentives received	44	134	116	0
Relationship with colleagues	1	43	250	0
Relationship with superiors	7	65	221	1
Career development (including promotion and advancement)	29	110	155	0
Facilitation of training	21	100	172	1
Work situation (such as working hours, night shift, and assignments)	22	111	161	0

Note: All questions are asked to respondents.
Source: PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

Table 3.8: Factors Which Predispose Nurses to be Conscious of Having Difficulties in Working as a Nurse in Indonesia

Difficulties in working as a nurse in Indonesia (n = 294)	Not applicable	Fair	Satisfied	Not applicable
Dealing with patient	149	126	19	0
Work risks/hazards	75	120	71	28
Limited opportunities for career development	126	103	51	14
Ratio of the number of patient and nurse	54	115	88	37
Low salaries and incentives	82	113	73	26
Inadequate hospital facilities	150	93	43	8
Poor working conditions (heavy duty, long working hours, night shift, etc.)	150	85	49	10
Inharmonious work relation with superiors	220	56	10	8
Inharmonious work relation with co-workers	224	56	10	4
Limited work competency and knowledge as nurses	183	86	23	2
Gender discrimination by patients	227	55	9	3
Gender discrimination by doctors/workplace management	229	52	11	2

Note: All questions are asked to respondents.
Source: PPK-LIPI, IDEA JETRO, ERIA Survey (2018).

4. Conclusion and policy implications

4.1. Conclusion

One important issue in Indonesia regarding nurse migration is the uneven distribution and availability of the nurse workforce for providing services throughout the country, and this issue is related to the internal migration of nurses. Another issue, related to international migration is the availability of job opportunities in some countries, especially in Asia (such as Japan, Singapore, Hong Kong, and Taiwan) that attract Indonesian nurses to migrate and work in those countries. In addition, the ASEAN Economic Community (AEC), established at the end of 2015, also promotes the movement of nurses within ASEAN Member States as one element of the AEC Blueprint 2025 is facilitating the free movement of skilled labour within ASEAN Member States for eight occupations, including nursing.

The results of this study in Jakarta and the surrounding areas show that about 28.6% of female nurses with no experience of working abroad had the intention to work abroad. Young and unmarried nurses seem to have a greater intention to work abroad. The opportunity to get more experience, skill improvement, and better career advancement are some reasons that can be regarded as pull factors to the destination countries for Indonesian nurses to migrate to work abroad. Since all nurses in the sample for the analysis of the factors influencing the intention to work abroad were currently working in Indonesia, a pleasant working environment seemed to hold them in their current job, and nurses working in such an environment were less likely to have the intention to work abroad. Meanwhile, work risk, such as risk/safety for women working at night, risks related to contact with patients with infectious diseases, and the use of hospital equipment, might have influenced their thoughts of leaving the country to work abroad.

Japan was the most preferred country amongst the female nurses who indicated an intention to work abroad. This might have been influenced by their awareness of the IJEPA programme, which allows Indonesian nurses to work as candidates of certified caregivers or candidates of registered nurses. The programme also provides them with the opportunity to acquire the status of permanent residence in Japan as certified caregivers or registered nurses if they pass the national exam after several years of working as candidates. The publicity by the National Board on Placement and Protection of Indonesia Migrant Labour (BNP2TKI) on this recruitment programme also broadens female nurses' knowledge of the opportunity to work in Japan.

The study shows that the majority of the nurses in the study sample had undergone training/courses to improve their nursing skills, mostly in Indonesia. Only about 2% of the nurse respondents had undergone training abroad. Most of them had also undergone training/courses funded by their workplace (hospitals/health services). This finding suggests that many employers are willing to provide funds for the career development of their nurses so that they can attract highly qualified nurses who can provide prime health services for the clients of their institutions. However, more than 50% of the sampled nurses stated that they had difficulties in their career development, and this finding can be interpreted as a need to establish a system to promote the career development of nurses for the improvement of nursing services in Indonesia.

4.2. Policy implications

Based on the available data from various sources and survey results, some policy implications can be proposed as follows:

1) Regarding nurse internal migration, the Government of Indonesia is recommended to develop programmes for distributing nursing school graduates evenly throughout the country, especially focusing on nursing schools in Jakarta and provinces in Java Island. Migrant nurse graduates (who come to Jakarta and other provinces in Java for education/nursing education) could be encouraged to return to their place of origin, especially those nurses from provinces where the nurse-to-population ratio is far below the government target ratio. The government should provide more incentives (besides the usual salary) for those returned nurses as well as nurses from other provinces (mainly from Jakarta and Java Island) who intend to work in the provinces with a low nurse-to-population ratio. National and local governments are encouraged to guarantee and provide employment opportunities (and incentives) for nurses who are intending to work in the provinces with a low nurse-to-population ratio.
2) The Indonesian government needs to synchronise its policy regarding the even distribution of nurses throughout Indonesia and its policy regarding the deployment of Indonesia nurses to work abroad.

3) Bilateral agreements between Indonesia and foreign countries on the recruitment of Indonesian nurses to work abroad have to take the optimal use of the skills of nurses educated in Indonesia into consideration.
   - If the destination countries need caregivers, the personnel who have specific caregiver qualifications should be recruited. Nurses should be provided with the status of full worker (not of a trainee) even in destination countries.
   - For those who wish to be recruited by destination countries as registered nurses, training and programmes to improve skills should be provided in Indonesia, in accordance with the needs of the destination countries. Taking Japan as an example here, the country is encouraged to provide information on the specific skill requirements to work as registered nurses there as well as to send trainers from Japan to Indonesia, if necessary. The information and training with trainers from Japan will provide the knowledge and capacity to help Indonesian nurse candidates pass the exam in Japan.

4) The nurses who return from other countries are very important human resources for Indonesia. The Indonesian government is encouraged to promote the optimal utilisation of such human resources. For example, the government can develop programmes for them to keep the skills and knowledge acquired abroad and utilise them as practical nurses in health facilities in Indonesia. These measures are required because there are some nurses who return to Indonesia but work as interpreters or in other occupations not requiring nursing skills.

5) Referring to the establishment of the AEC and the promotion of the movement of nurses within ASEAN Member States, the Indonesian government needs to provide Indonesian nurses with opportunities to increase their capacity to compete with nurses from other countries, both to work in Indonesia (to compete with nurses from other ASEAN Member States who intend to work in Indonesia) and to compete in the ASEAN labour market (to work in other ASEAN countries).

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4

The Ageing Society and Human Resources to Care for Older People in Thailand

Patcharawalai Wongboonsin, Yupin Aungsuroch, and Naomi Hatsukano

Abstract

Thailand has attained the status of an ageing society. By 2025 and 2040, Thailand is projected to transform into an aged and super-aged society, respectively. According to statistics, family members are the main source of assistance for older people's daily living activities. Through the government's policies, communities are also expected to play a greater role in older people's care. To support these families and communities, together with the recent appearance of better-qualified nursing homes, the trained caregivers' role is becoming more important. Standard training programmes have to be prepared by the relevant institutions and an official caregiver certification is necessary as a professional qualification to ensure high-quality care. Some Thai caregivers are working abroad, but the number is still limited.

Keywords: Education, Human Resources, International Migration, Thailand, Ageing Society

1. Introduction

Thailand has attained the status of an ageing society.[1] The Thai Government has been preparing policies for the care of the growing elderly population since the 1980s. Family members are still the most important caregivers for aged parents. At the same time, local communities are expected to play a more important role. To support families and

[1] In this paper, an ageing society means a society in which more than 7% of the population is 65 years or older; an aged society means a society which has more than 14% of the population aged 65 years or older; and a super-aged society is when more than 21% of the population is aged 65 years or older.

communities, and to support the nursing homes and long-term care facilities for older people that have gradually appeared in the 2010s, the role of trained caregivers with professional knowledge is becoming more important and the demand for them is growing. Firstly, in this chapter, we introduce the progress of population ageing and the current status of care provision for older people based on statistical data, followed by discussions on the Thai Government's policies and programmes for population ageing. Secondly, the current situation and challenges regarding the management of the human resources of trained caregivers are analysed. Thirdly, we introduce some case studies of nursing homes in Thailand where trained caregivers work. Finally, the caregivers' opportunities to work abroad are discussed.

2. Status of population ageing and human resources in Thailand: Statistics and policy

2.1. Statistical situation

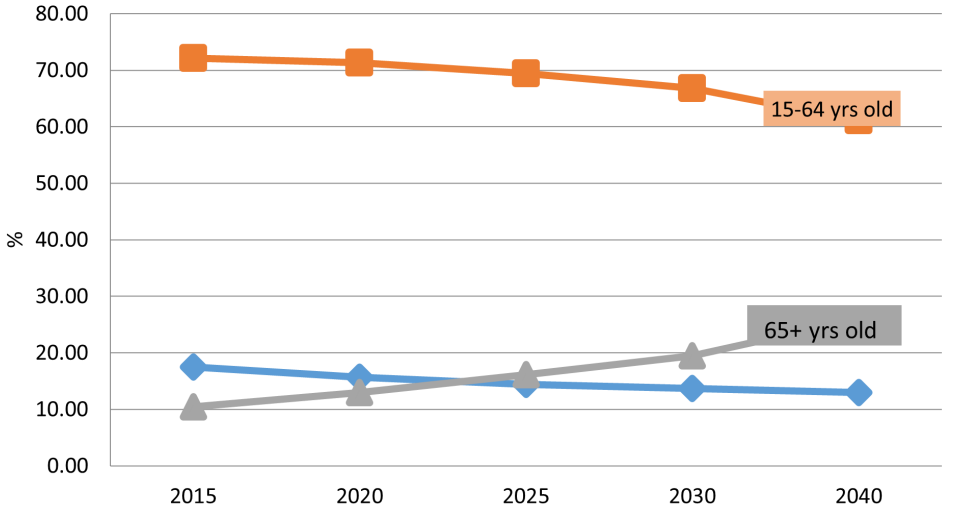
During the process towards the realisation of the ASEAN Vision 2025 and the new ASEAN Vision 2040, Thailand exemplifies a society at a crossroads due to a series of prominent changes in the demographic and socio-economic landscape.

Based on the latest (2010) national census (NSO, 2012), Thailand has a population of 65.98 million, as of 1 September 2010, of which 50.9% are female and 49.1% male, with a sex ratio of 96.2 (males to 100 females). The population in Thailand is increasing at a declining rate, from a 3.2% annual rate of population growth in 1960 to around 2% in 1990, and to 0.8% by the time of the 2010 national census. This is attributable to the fact that Thailand is experiencing a drastic decline in its fertility rate, from more than six births per woman before 1961 to 1.41 in the 2000s (Wongboonsin, Keeratipongpaibul, and Wongboonsin, 2018). According to the United Nations (2013), Thailand's total fertility rate (TFR) is projected to reach its lowest point of 1.36 births per woman by 2020. Thereafter, the TFR is projected to increase slightly, due to population momentum, to 1.82 births per woman by 2100.

In the meantime, based on the data from the United Nations (2013), Thailand is experiencing an upward trend in life expectancy at birth. This has risen from 51.6 years in 1950–1955 to 73.3 years by 2005–2010. Assuming the median variance, it is expected to increase further to 80.5 years by 2050, and 86.4 years by 2100. As in other countries,

female life expectancy in Thailand has remained higher than that of males, at 77.2 and 71.0 years, respectively, during 2005–2010.
Accordingly, the demographic structure in Thailand is changing rapidly. While the proportion of children and the working-age population is declining, that of the elderly is increasing.

Figure 4.1: Demographic Shift by Broad Age Groups in Thailand, 2015–2040



Source: Wongboonsin and Wongboonsin (2015), based on data from the United Nations (2013).

Figure 4.1 shows the demographic shift by broad age groups in Thailand from 2015 to 2040, and Thailand has currently attained the status of an ageing society. By 2025 and 2040, Thailand is projected to transform into an aged and super-aged society, respectively. The proportion of the Thai population aged 65 years and above is projected to increase from 10% of the total population in 2015, to 16% by 2025, 19.5% by 2030, then more dynamically reaching 26% by 2040 (Wongboonsin and Wongboonsin, 2015).

One may note that the process of population ageing in Thailand is not homogeneous. In 2010, 9 of 77 provinces were below the threshold of 7% elderly aged 65 years and above. This will continue until 2030, when all provinces will have an elderly group above 7% of the total population. At that time, 69 provinces will be aged with the elderly accounting for over 14% of the population.

The current snapshot and demographic projection for Thailand have raised concerns whether families will continue to play the same roles as effectively in the future. In other words, the changing demographic and socio-economic circumstances at the macro level place enormous pressure on the working-age population, particularly on females, who provide care and protection for their family members (Wongboonsin, Keeratipongpaibul, and Wongboonsin 2018). This is given the notion that the rapid drop in TFRs, the lengthening period of vulnerability over the lifecycle, and other temporal social changes have created a drastic shift in the population's age structure, which may produce a more complex dimension of care that makes it difficult for the working-age cohort to sustain informal care over the longer term without formal support.

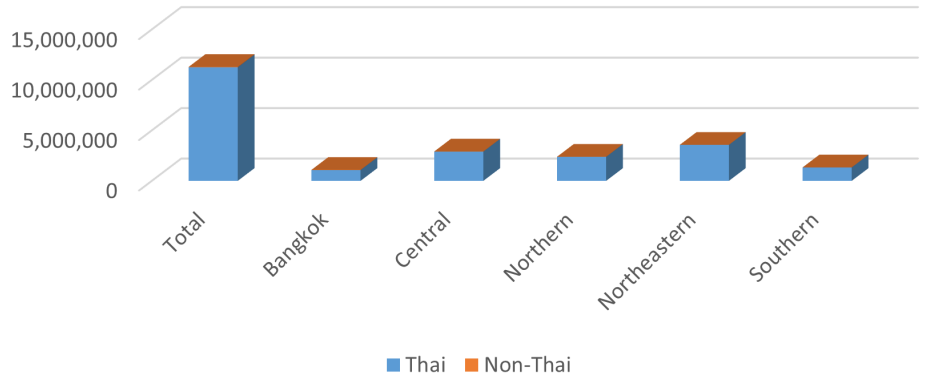
According to Keeratipongpaibul (2013), an estimation reveals that the province of Chai Nat in the central region of Thailand had the highest old-age dependency ratio[2] in 2010 (31.5%), and the lowest old-age dependency ratio at 10.7% was in Samut Sakorn, another province in the central region. By 2030, Uthai Thani, a province in the northern region, and Chonburi, a province in the eastern region, are projected to have the highest (77.3%) and the lowest (23.1%) old-age dependency ratios in Thailand, respectively. Samut Sakorn in the central region, Rayong in the eastern region, and Phuket and Krabi in the southern region of Thailand are also projected to have relatively low old-age dependency ratios by 2030. This is due to the emerging economy, which will attract the migration of a younger workforce for employment opportunities.

The National Statistical Office of Thailand, the NSO, has carried out a regular survey of older persons in Thailand. The latest was carried out during June–August 2017, covering a sample size of 83,880 households in both municipal and non-municipal areas across the Kingdom of Thailand to estimate the situation of 11,312,447 older people.

As shown in Figure 4.2, the 2017 survey was not limited to just Thai people. Out of the total 11,312,447 older people, defined as those aged 60 years and above, there were 35,476 non-Thai older people. In Bangkok, the survey's targeted older people included 1,071,462 Thai and 15,897 non-Thai people. In the central region, the survey included 2,900,686 Thai and 9,031 non-Thai older people; in the north, 2,381,572 Thai and 6,472 non-Thai older people; and in the northeast, 3,568,552 and 1,508, respectively. Finally, the southern region's older people included 1,331,419 Thai and 2,567 non-Thai people.

[2] The old-age dependency ratio is the ratio of the number of elderly people at an age when they are generally economically inactive, compared to the number of people of working age.

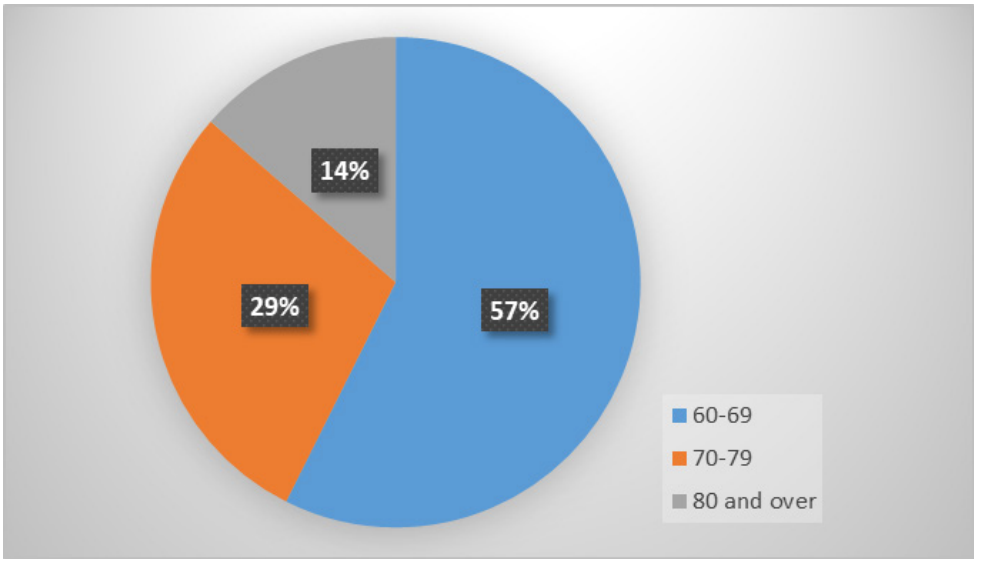
Figure 4.2: Number of Older Persons in Thailand by Nationality, 2017



Source: 2017 Survey of Older Persons in Thailand.

The participants in the 2017 Survey of Older Persons in Thailand were mainly in the 60–69 age group, followed by those who were 70–79 years old, and 14% who were aged 80+ years (Figure 4.3).

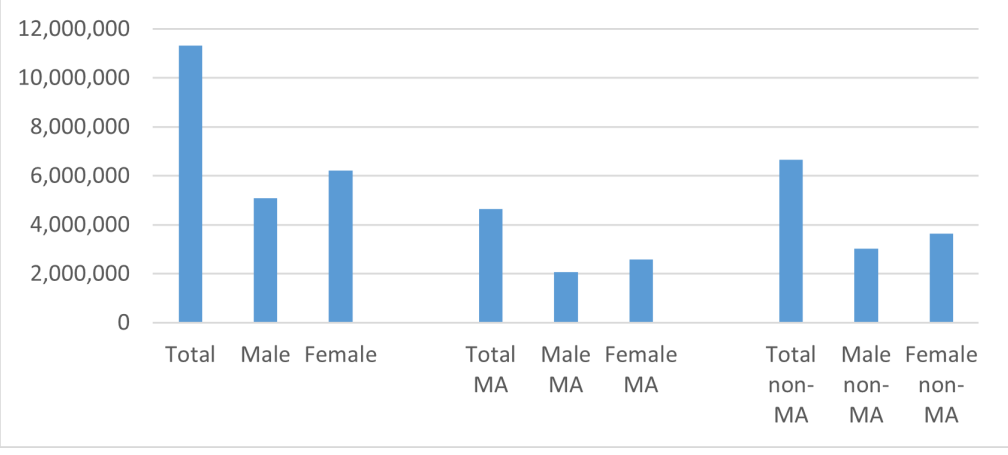
Figure 4.3: Percentage of Participants by Age Group in 2017 Survey of Older Persons in Thailand



Source: 2017 Survey of Older Persons in Thailand.

As shown in Figure 4.4 out of the total 11,312,447 older people, 5,083,681 were male and 6,228,766 were female across the whole country. There were 2,062,919 males from municipal areas and 3,020,762 from non-municipal areas.[3] Of the women, 2,593,850 were from the municipal areas and 3,634,916 persons were from non-municipal areas.

Figure 4.4: Number of Older Persons by Gender in Thailand, 2017

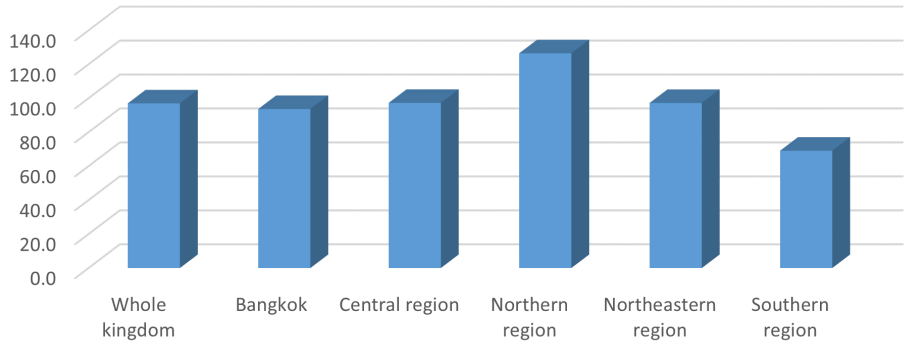


MA = municipal area.
Source: 2017 Survey of Older Persons in Thailand.

Figure 4.5 depicts the ageing index, or the ratio of the number of older people per 100 people younger than 15 years old in Thailand. Based on the data from the 2017 Survey of Older Persons in Thailand, the average ageing index for all of Thailand was as high as 97. Yet, the ageing index of the northern region was much greater than that of the whole country. This region reached an ageing index of 126.4. Meanwhile, the south had the lowest ageing index at 69.7 in 2017.

[3] Municipal areas mean a locality which has a Royal Decree issued under the Municipal Act of 1953 and is established as a municipality and the Sanitation Change Act to be a Sub-district Municipality 1999 as a Sub-district Municipality by specifying the boundaries of that municipality as well. Non-municipal areas mean the area outside the municipality, also known as the village. Municipalities in Thailand are divided into three types according to the population and income of the municipality. In the Municipal Act of 1953 (Section 9, 10, and 11) a Sub-district Municipality consists of the locality in which the Ministry of Interior has announced the status of the Sub-district municipality. The announcement of the Ministry of Interior specifies the name and municipality area as well. A Town Municipality is a locality with a population of more than 10,000 and a reasonable income for the performance of duties required by this Act. A City Municipality is a locality with a population of 50,000 or more, with sufficient income to perform duties required under the Act.

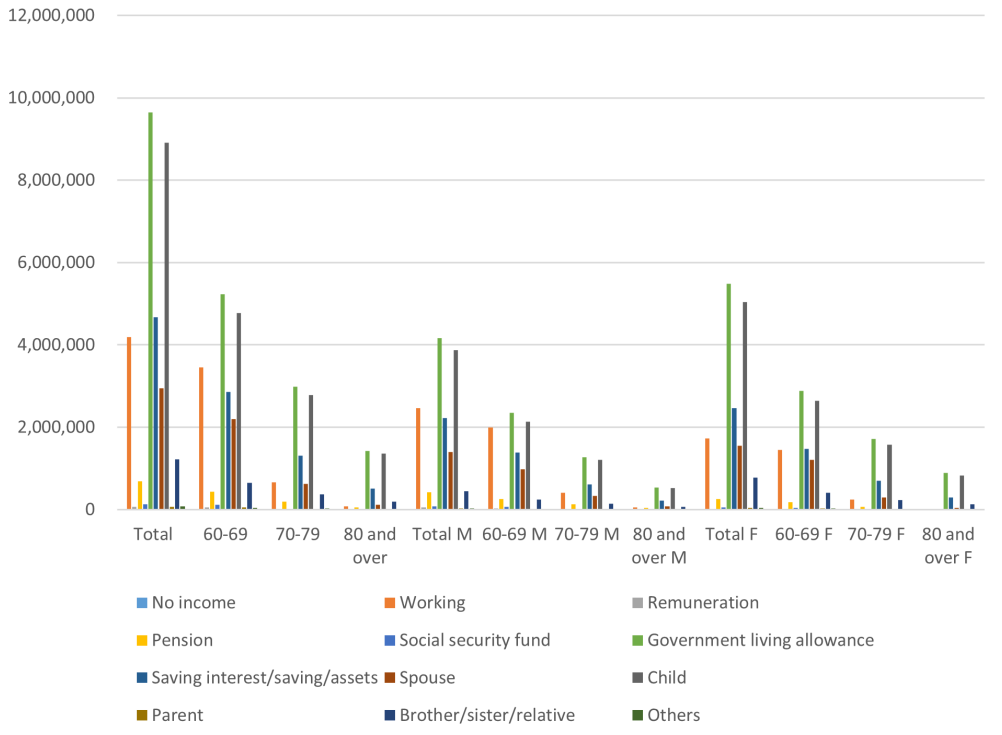
Figure 4.5: Ageing Index in Thailand, 2017



MA = municipal area.
Source: 2017 Survey of Older Persons in Thailand.

The 2017 Survey of Older Persons in Thailand investigated older persons by source of income. Figure 4.6 shows that there were various sources of income for older people in Thailand during the 12 months before the date of the interviews, adopting a multiple response approach. From the perspective of private transfers, parents, spouses, brothers/sisters, and children were reported as their source of income. The government's living allowance, pension, and social security funds are the reported sources of income from the perspective of public transfers. They also earned from their own sources of income, which included working remuneration and savings interest/savings/assets. Overall, the data show that most older persons participating in the 2017 survey received the governmental living allowance. Children were revealed to rank second as the source of income, followed by savings interest/savings/assets, working, spouses, brothers/sisters, and pensions.

Figure 4.6: Number of Older Persons by Source of Income, Age Group, and Gender, 2017



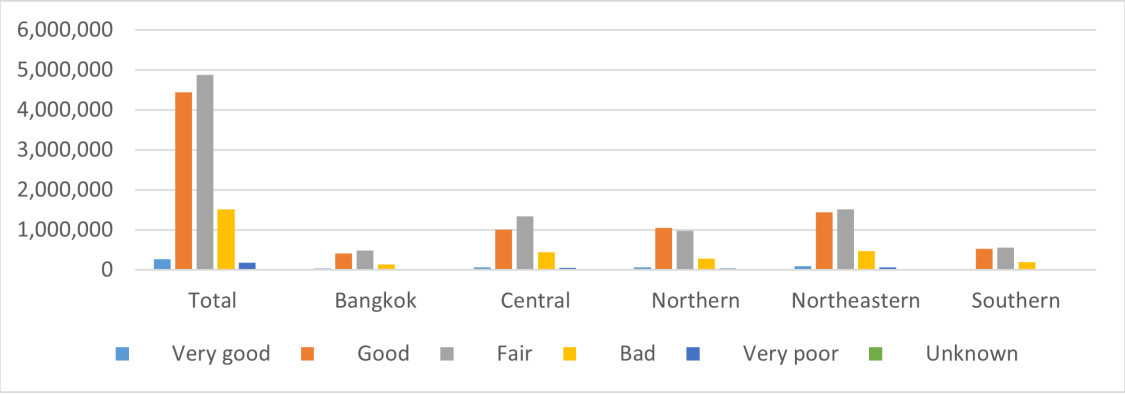
Source: Calculated from 2017 Survey of Older Persons in Thailand.

Despite the governmental living allowance as a source of income reported by the majority of the 2017 survey's participants, this study opines that the survey's results support a previous study to a certain extent. According to Wongboonsin, Keeratipongpaiboon, and Wongboonsin (2018), Thailand belongs to a family-based welfare regime. In other words, Thai society has so far largely relied upon private, non-monetary transfers within families. This regime is borne out of a long-standing norm whereby the family has an important role in the family's care arrangements, and parents rank superior in social position and age. In such a society, the family members have traditional roles and designations based on a hierarchical structure that defines the relationship between husband and wife, parents and children, and older and younger siblings. This is expressed in terms of the expected responsibility to support, in both cash and kind.

One may note, also, that the 2017 survey's participants were active older persons to a certain extent, given that working was reported as a source of income. This seems to support the data on the self-health assessment shown in Figure 4.7. Overall, the majority of the survey's participants rated their own health as fair, followed by good.

However, there were 1,518,324 older persons who considered themselves to have a bad health condition. The number of people reporting bad health was highest in the northeast, followed by people in the central region. The lowest number of older people that considered themselves to be in bad health was in Bangkok (Figure 4.7).

Figure 4.7: Number of Older Persons by Self-health Assessment in Thailand, 2017

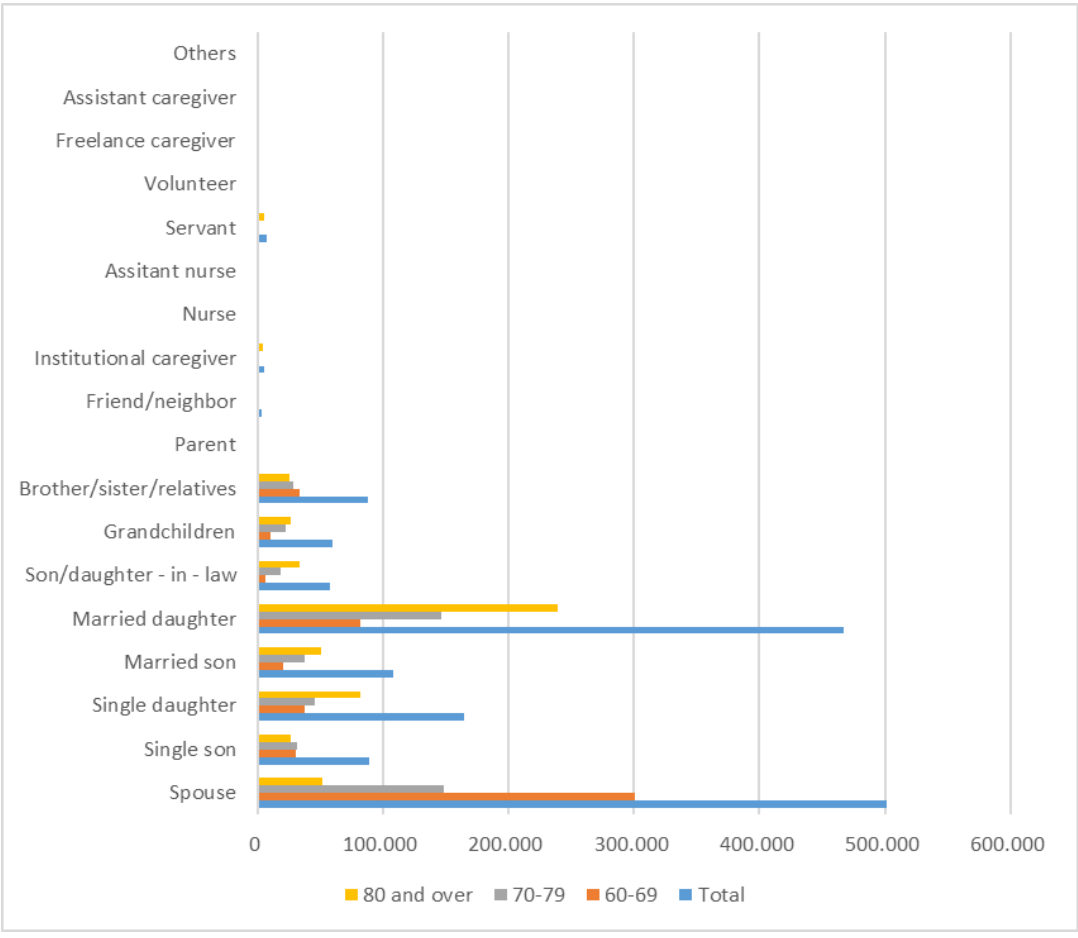


Source: 2017 Survey of Older Persons in Thailand.

The 2017 survey's data revealed that there were 16 categories of those taking care of the older persons as part of their daily activities, along a multi-response approach. They are the spouse, single son, single daughter, married son, married daughter, son/daughter-in-law, grandchildren, brother/sister/relatives, parents, friend/neighbour, nurse, assistant nurse, institutional caregiver, freelance caregiver, assistant caregiver, volunteer, servant, and others (Figure 4.8).

Overall, Figure 4.8 reveals that familial support was the main source of assistance for the elderly's daily living activities. The majority of the older people participating in the 2017 survey were cared for by their spouse, followed by married daughter, single daughter, married son, single son, and brother/sister/relatives. Those in the age group of 60–69 years old were mainly cared for by their spouse, while those in the 80+ age group were mainly cared for by a married daughter. For these age groups, almost the same numbers of 70–79 year-old people answered that they were cared for by married daughters and spouses, but the number cared for by their married daughters was slightly bigger than for spouses. The data reveal that non-family members play a very small role in daily-activity care provision, even in the age group of 80+ years old.

Figure 4.8: Number of Older Persons by Main Caregivers for Daily Activities by Age Group, 2017



Source: 2017 Survey of Older Persons in Thailand.

2.2. Governmental policies and programmes related to older persons

Elderly welfare has been an issue of concern in Thailand for decades. This was reflected in as early as 1982, when the National Elderly Council was established to begin addressing the issues impacting the elderly. Then, in 1991, the National Committee of Senior Citizens was established in response to a resolution by the UN Assembly on elderly persons' rights with respect to autonomy, involvement, care, self-satisfaction, and esteem.

Thailand is currently implementing the Second National Plan for Older Persons (2002-2021) with five implementation strategies (National Commission on the Elderly, 2009). They are:

- Preparation for quality ageing
- Promotion of well-being by older persons
- Social security for older persons
- Management system and personnel development at the national level
- Research for policy and programme development support, monitoring, and evaluation for the Second National Plan for Older Persons every five years

The Second National Plan for the Older Persons is based on the philosophy that 'the elderly are not a vulnerable group nor a social burden, but able to take part as social development resources, so they are entitled to recognition and support by the family, community, and the State, to lead a valuable life with dignity and sustain their health and living standard for as long as possible' (National Commission on the Elderly, 2009: 1). The objectives of the plan are fivefold: 1) to encourage older persons' well-being, whereby they can lead their lives as an asset to society with dignity and personal independence and autonomy with reliable security; 2) to raise society's conscience regarding the respect for and recognition of the elderly's valuable contribution to society, whereby their valuable experience shall be promoted for as long as possible; 3) to raise all people's awareness regarding the necessity for readiness preparation for quality ageing; 4) to encourage the people, family, community, and the local, public, and private sectors to realise and take part in actions involving the elderly; and 5) to formulate the framework and guidelines for good practice regarding the elderly for all concerned parties to observe aiming at an integral and comprehensive implementation on the elderly persons' mission (National Commission on the Elderly, 2009: 2–3).

The Act on Older Persons was enacted in 2003 and has been in force since 1 January 2004, consisting of 24 sections. The focus of the act includes: 1) elderly persons' rights; 2) national mechanisms for the elderly; 3) tax privileges for children who take care of their parents; and 4) an elderly person fund. The National Commission on the Elderly is prescribed to be established by the Act on Older Persons.

In 2014, the elderly welfare budget – which covers the old civil servant pension scheme, living allowances for the elderly, and the government's contribution to the Government

Pension Fund, the Social Security Fund, and the National Savings Fund – amounted to B270 billion, or 2.1% of gross domestic product (GDP). The budget is expected to increase to B680 billion by 2024, accounting for about 3% of the anticipated GDP. Moreover, the budget for pension-related schemes is expected to increase from B287 billion currently to B698 billion by 2024.

There are strong expectations by policy makers for families to continue to perform their traditional role for the care of elderly people. This is amid concerns arising regarding how the Thai elderly can be helped to be better-off, and how the welfare schemes could be made sustainable in the years to come.

From the perspective of public transfers, public welfare for the elderly in Thailand covers the following: 1) the former civil servant pension scheme; 2) living allowances for the elderly and the government's contribution to the Government Pension Fund; 3) the Social Security Fund; and 4) the National Savings Fund (Wongboonsin, Keeratipongpaibul, and Wongboonsin, 2018).

The government's current policies and programmes are in line with the Second National Plan for Older Persons (2002-2021) mentioned above. A partial welfare state is accordingly the option taken by the Thai government. Recently, to ease the financial burden on the government, new measures for old-age security have been launched to promote a social safety net for security and quality of life in old age. Intergenerational family relationships have been strengthened through different policy measures, in addition to the promotion of a positive attitude towards the elderly, health promotion for the elderly, social protection for the elderly, and old-age security programmes. The latter includes old-age employment, housing development plans for low-income and lower-middle income earners along a public-private partnership (PPP) approach, reverse mortgage loans, and elderly-friendly banking services. Amongst the measures for old-age security, those relating to the pension system are in relatively slow development (Wongboonsin, Keeratipongpaibul, and Wongboonsin, 2018). Thailand also opts for a community-based system for long-term care. A 'sub-district role model' is relied upon to strengthen community collaboration with other stakeholders – namely family, the local government, the private sector, and several governmental agencies – in the provision of services for dependent elderly people in the community to serve their needs. Yet, one may note that this is still at an early stage of building capacity.

2.3. Human resource management for the care of older people in Thailand

a) Overview

The older population in Thailand continues to grow, which is leading to high demand for caregivers. However, being a caregiver is not an easy task; there are many factors to consider, including each individual's availability and care-giving capabilities. This section presents brief information on today's caregivers in Thailand, the Thai Government's efforts, training for caregivers, curriculum, regulation, and certification.

Today, Thailand faces the progressive ageing of its population, and the country is ranked as the second-most aged in Southeast Asia. The proportion aged 80 years and above is estimated to rise tenfold between 2000 and 2050 (Knodel et al., 2018). The majority of people hold the Buddhist principle whereby most long-term care is provided informally at home by family members.[4] As in other Asian countries, family members are the ones to support older Thais for personal assistance with the activities of daily living (ADL) (Knodel et al., 2015).

However, Thailand has started to face difficulties in providing care for its elderly citizens due to the increased out-migration of adult children, which have raised concerns about the sustainability of the home-based care by family members model in the future (Knodel, 2014; Knodel et al., 2013). In addition to a lack of availability of caregivers, unequal access to services, insufficient quantity and quality of health resources (i.e., infrastructure, manpower, and financing), and a lack of coordination within and between health institutions in delivering care services remains (Suwanrada et al., 2014). Therefore, efforts to solve these issues are needed.

b) Government efforts for the care of older persons

The Thai Government is fully aware of these challenges and has set up a working team to revise the Health Development Strategic Plan for the Elderly (2013-2023) to address long-term care for older persons by combining assistance within the family and a support

[4] Suwanrada et al. (2014) explain that the Buddhist principle of filial piety prevailing in Thailand means that most long-term care is provided informally at home by family members. They also mention that given the current demographic changes, Thai families have started to face difficulties in elderly care issues.

system of health care and social services within their own communities (Suwanrada et al., 2014). This emphasises the need for the community and local administrative organisations to cooperate in implementing the long-term care system, including allocating a budget for the purpose. The components of the system include databases on older people, good-quality clubs for older people, volunteers to provide home-based care for older people, preventive dental services, and a system to ensure care for older people who are home- or bed-bound (Foundation of Thai Gerontology Research and Development Institute and College of Population Studies, 2012).

To provide home-based assistance for older people, the Home Care Service Volunteers for the Elderly Program was launched by the Bureau of Empowerment for Older Persons (now Department of Older Persons) in 2003, to establish a system of community-based care and protection for older persons with chronic illnesses, especially for those who are bedridden, who have no caregivers, or who are underprivileged (Knodel et al., 2018). By 2013, some level of services in all communities throughout Thailand had been provided by the Bureau of Empowerment for Older Persons, involving over 51,000 elderly home care volunteers responsible for nearly 800,000 older persons (Ministry of Social Development and Human Security, 2013). However, the extent and quality of the services provided by such home care volunteers varies greatly across communities.

In 2011, a new community care policy was developed by the Thai Government as part of a project in Lam Sonthi District, Lopburi Province. A fund of US$17.4 million was created by the National Health Security Office (NHSO) to provide long-term care facilities for older people (Khongboon and Pongpanich, 2018). In 2016, a trial programme was announced to cover 1,000 sub-districts, including 100,000 severely disabled individuals (National Health Security Office, 2015).

There are only 12 institutional old-age homes, called Social Welfare Development Centres for Older Persons (introduced in section 3.1), supported by the national government with under 2,000 residents, and 13 others under the supervision of the Department of Local Administration (Foundation of Thai Gerontology Research and Development Institute and College of Population Studies, 2012).

c) Elderly care stakeholders at the community level

Direct stakeholders providing care for older people at the community level include three entities: senior citizen centres, sub-district health-promoting hospitals, and sub-district administration organisations.

Senior citizen centres

These are places for older persons to develop themselves and extend their social network at the local level. The centres belong to older persons, are run by older persons, and are for the benefit of older persons, with regulations, physical locations, and separate funding. The activities of the centres are mainly arranged according to the demands and interests of the members. The first senior citizen centres were established in Thailand on 20 December 1962 (formerly called the Senior Citizen Assembly) by the Neuroscience Research Foundation under the Royal Patronage of H.M. the King, Nerve System, Phaya Thai Hospital, and based on the concept of Professor Doctor Prasop Ratanakorn (Daranee, 1997; Uttawichai, 1996). By 2008, 19,475 senior-citizen centres had been officially established. But, it is likely that more centres have been unofficially established under the support or supervision of other organisations (Council of the Elderly of Thailand, 2008). The role of senior-citizen centres are for home visits and checking physical health, such as measuring blood pressure, reviewing health conditions related to food, diet, and exercise, along with monitoring mental health by talking and allocating a companion, organising music, folk art, handcrafts, planting, and travel, etc. The centres help to arrange the home environment to be more elderly-friendly, such as by organising the bedroom to be bright, with good ventilation, installing handrails in the bathroom, changing squat toilets to sitting toilets, or adjusting stair railings and inclines (Suwanrada et al., 2014).

Sub-district health promotion hospitals

These are governmental authorities at the primary care unit level under the control of the Department of Health, Ministry of Public Health. Their key role is to prevent disease, as well as promote and restore health. In addition to having government officers who are responsible for the hospitals' operation, the Ministry of Public Health also arranges for village health volunteers, who are community members trained by the sub-district health promotion hospitals to provide primary, first-stage health care to the people in the community and, in cases where a situation is beyond the capability of the village health volunteer, to refer the elderly to a hospital. The key role of the sub-district health promotion hospitals is to create a database of elderly; coordinate and work closely with

professional nurses, physical therapists, and occupational therapists at the community hospitals using ADL; arrange home visits to follow up; and provide advice and knowledge to the village health volunteer so that they can take care of the patients under the supervision of the sub-district health promotion hospital (Suwanrada et al., 2014).

Sub-district administration organisations

Local administrative units have established four welfare plans for older people: 1) A health services plan; 2) a plan to promote living together and strengthening elderly organisations; 3) an older people's and disabled people's occupation and income promotion plan; and 4) a plan to arrange volunteers to take care of older people and disabled people (Foundation of Thai Gerontology Research and Development Institute, 2008). The Second National Plan on Older Persons (2002-2021) mandated that one of the missions of the local administrative units is to arrange for elderly services in the community, comprising: 1) multi-purpose centres for older people, 2) day-care centres for older people, 3) elderly people's home visits, 4) healthcare services at the homes of older people, 5) transportation services for older people in the community, 6) systemisation of the promotion of elderly care, 7) elderly care volunteers, 8) training for caregivers and volunteers, and 9) authorities/third parties to train caregivers and volunteers for elderly care inside the village (Prachuabmoh et al., 2008).

d) Training for caregivers

The challenge in Thailand is the insufficient numbers of qualified and skilled home care volunteers. Therefore, caregiver training is needed. In Thailand, caregivers refer to persons who have been trained in child or elderly care for at least 420 hours or 3 months. To provide training for caregivers, we first need to understand the needs of the older people.

Needs of older people

Studies (Ayudhya et al., 2007; Rittirong, et al., 2014) provide the types of needs for older people as follows:

Meal preparation refers to meals that may be cooked at the house where the older person resides, or cooked elsewhere and brought to the house of the older person.

Personal care includes any care or assistance regularly or occasionally given by a person to an older person who is not able to care for themselves due to physical limitations. Personal care, for example, includes feeding food, bathing, toileting,

dressing, and caring for them when they are sick.

Mobility involves the changing of positions, such as from supine to sitting, standing, for going upstairs, and ambulatory with mechanical or a caregiver's assistance.

Use of medication specifies the preparation and dosage of medicine. Most older people and caregivers do not have enough basic language skills to read and write. Caregivers need to remember what the doctors prescribe. Main caregivers will pass the information along by word of mouth if there are many caregivers in a home.

Sleeping and monitoring. The caregivers have to care for the older people 24 hours a day. They must make sure the older people do not fall or get up and walk unaided. At night, they have to be ready to get up and turn their position or check if they need to change their diaper, leading to a lack of sleep and health deterioration.

Transportation refers to assistance and transportation given to older persons for medical appointments or treatments and to do business in the community.

Financial support refers to any financial assistance given directly to an older person, or to the household where the older person resides. This includes money the older person receives for expenses, such as for household consumption and medical treatment.

Emotional support includes any action, such as talking, consulting, or discussing, which expresses the giver's feelings of affection, sympathy, and/or understanding toward the older persons.

Institutions that provide training for caregivers

Caregiver training in Thailand is provided by public and private institutions. Public institutions include 1) the Office of Non-Formal and Informal Education, Ministry of Education, 2) Department of Health, Ministry of Public Health, 3) Department of Skill Development, Ministry of Labour, and 4) Department of Older Persons, Ministry of Social Development and Human Security; while there are about 76 private institutions that provide training for caregivers.

Regulations for caregivers and care for older persons

The caregivers and elderly care in Thailand are arranged and regulated by the following regulations:

1) The Act on Older Persons (2003) by the Department of Older Persons, Ministry of Social Development and Human Security, Section 10, established a community-based care system for older persons to cooperate and coordinate with the central, provincial, and local authorities and the state's enterprises and other organisations that facilitate older persons' access to the protection, promotion, and support they are entitled to under this Act and other relevant laws.
2) The Office of the Decentralization to the Local Government Organization Committee, in providing personnel and personnel expenses for caring for dependent elderly/long-term care and to support caregiver training for dependent elderly.
3) The Ministry of Education's regulation in 2003 regarding the determination of private school standards and curriculum covers places and buildings, teachers, courses, the capacity of the students, evaluation of learning, study fees and school management, and the school system establishment and operation.
4) The Department of Skill Development, Ministry of Labour provides the National Labour Standards Test (a test of the knowledge, ability, and attitude of the occupation according to the criteria set by the National Skills Standard), arranging the standards and the qualification of the test for the elderly care profession for Level 1.
5) The Ministry of Public Health provided guidelines for controlling the operation of elderly care services at home in 2010.

Training curricula for caregivers

There have been various curricula for caregiver training courses, as follows:

1) Training course by the Ministry of Social Development and Human Security for three days (minimum 15 hours) by lectures and practices. The content of the course includes general knowledge about older people, ageing change, elderly psychology, health promotion for older people, elderly care skills, basic care for older people, morality and ethics in caring for older people, services and networks for older people, the role of elderly care volunteers, and elderly care practices.
2) Training course by the Ministry of Public Health for three days (minimum 18 hours) with 15 hours of lectures and 3 hours of practical training. The content includes general knowledge about older people, ageing change, elderly psychology,

health promotion for older people, elderly care skills, basic care for older people, morality and ethics in caring for older people, services and networks for older people, the role of elderly care volunteers, and elderly care practices. Participants are considered to have passed the test if their scores for the practical, knowledge, and attendance ratio are more than 80%, and the moral and ethical test should be 100%.

3) Training course by the Ministry of Public Health for two weeks, with 30 hours of lectures and 40 hours of practical. The content includes the need for elderly care, elderly concepts, common diseases in older persons, emergency care and first aid for older persons, basic care for older persons, caring for long-term older people with dependency, drug use by older persons, health promotion for older persons, elderly psychology, providing a suitable living environment for older persons, indigenous knowledge and elderly care, elderly rights/labour laws, the roles and ethics of older persons' caregivers, recreational activities, and elderly care practices. Participants are considered to have passed the test if their scores for the practical, knowledge, and attendance ratio are more than 80%, and the moral and ethical test should be 100%.

4) A 420-hour training course provided by the Ministry of Public Health with 115 hours of lectures and 255 hours of practical. The content includes the needs for elderly care, elderly concepts, common diseases in older persons, emergency care and first aid for older persons, basic care for older persons, caring for long-term elderly people with dependency, drug use by older persons, health promotion for older persons, elderly psychology, providing a suitable living environment for older persons, indigenous knowledge and elderly care, elderly rights/labour laws, the roles and ethics of elderly caregivers, recreational activities, English skills, computer skills, and elderly care practices. Participants are considered to have passed the test if their scores for the practical, knowledge, and attendance ratio are more than 80%, and the moral and ethical test should be 100%.

5) A 420-hour training course provided by the Ministry of Education with 300 hours of lectures and 120 hours of practical. The content includes principles of elderly care, elderly psychology, recreational activities for older persons, nutrition for older persons, cleaning and storing the home equipment, Thai and English language, the roles and ethics of elderly caregivers, health education, labour laws, and elderly care practices. Participants are considered to have passed the test if the scores for the practical, knowledge, and skill performance are more than 50%, and the attendance ratio should be more than 80%.

6) A 420-hour training course provided by the Ministry of Labour, with 162 hours of lectures and 258 hours of practical. The content includes activities to improve work habits, work safety, elderly psychology, first aid for older persons, basic laws related to the caregivers' profession, principles of elderly care, basic work for elderly care, elderly care, nutrition for older persons, recreational activities for older persons, occupational care for elderly caregivers, basic computer skills, English at work, and personal business. Participants must complete at least 80% of the study time and pass an assessment by the Skill Development Institute.

Given the different types of training courses above, it remains unclear which one candidates need to follow, or for which caregivers can be said to be 'competent'. Is one training enough? Should a caregiver join any or all six courses? These questions need further exploration to develop unified training that can be accepted in all institutions.

Instructors, the target population, and certificates for training

The instructors of caregiver training include nurses, physicians, therapists, and pharmacists. The target population for such training varies. For 18 hours of training, the target is volunteers who care for older people in their family (grandchildren of the elderly) and volunteers for general elderly care. For 70 hours of training, the target population is village health volunteers and elderly caregivers, and for the 420 hours of training, the target is all individuals. After the training is completed, all the participants who pass the criteria will be awarded certificates from the institutions that provided the training.

2.4. Thailand Professional Qualification Institute

The Thailand Professional Qualification Institute (TPQI), is an organisation under the supervision of the Prime Minister of Thailand, established as an accredited registrar of personal competency according to the relevant occupational standards (TPQI, 2014). In order to be skilled trainers for caregivers, each individual should pass an occupational standard test and receive certification. There are four levels of occupational standards based on the characteristics of outcomes, qualification pathways, and performance. The details of each level are described in Table 4.1. The four levels are to describe the levels of skills of caregivers from the lowest (level 1) to the highest (level 4). These standards, however, are to maintain and improve the personal competency of caregivers in order to provide high-quality care.

Table 4.1: Levels of Occupational Standards Based on the Characteristics of the Outcomes, Qualification Pathways, and Performance

Level 1	• *Characteristics of outcomes* include performing basic routine tasks in general, being able to solve basic problems in the operation in a limited way, the ability to identify nutrition details, daily activities, cleaning environmental care, ability to work in the body and mind care at Level 1, social aspects of environmental management, and role of ethics for elderly caregivers with good service. • *Qualification pathways* include age of not less than 18 years, not being a person with bad behaviour, a medical certificate stating that they are healthy, not insane or mentally ill, graduating not lower than primary level or equivalent, having knowledge and skills in caring for the elderly for at least one year, or having passed the training course test. • *Performance* includes taking care of nutrition for the elderly with hygiene, elderly hygienic cleaning, preparing medicine for the elderly correctly and completely, following the roles and duties of caring for the elderly correctly and efficiently, and complying with the code of ethics for elderly care.
Level 2	• *Characteristics of outcomes* include the ability to solve basic problems that are found regularly by applying the theories, tools and basic information, competent in the process of safety and health in the workplace, and to support the steps other than the initial operation. • *Qualification pathways* include being a person who has passed the assessment to upgrade from professional qualification Level 1, has passed the training course on elderly care that covers the content and knowledge in all aspects, has received rehabilitation training for elderly care at home during work at least every two years, and has experience of caring for the elderly for at least two years or who has passed the training course test. • *Performance* includes selecting food for the elderly appropriately, supervising daily activities for the elderly with accuracy, completeness, and quality, promoting the exercise and psychological aspects of elderly correctly and appropriately, and providing hygienic and hygienic equipment and tools for the elderly.

Level 3	• *Characteristics of outcomes* include persons with knowledge and skill at the level of specialised skill and technique in the operation, there are various thinking processes and practices, able to solve technical problems along with using the manual and to observe the work, and clarifying and improving. • *Qualification pathways* include being qualified to advance to the level of professional qualification Level 3, passed the elderly care curriculum that covers the content and knowledge in all aspects, and receiving training in specialised care for the elderly. • *Performance* includes caring for the prevention of complications by the elderly correctly and safely, promoting the stimulation and rehabilitation of the elderly by correct and appropriate methods, and practice in providing tube feeding for the elderly by the correct and safe method.
Level 4	• *Characteristics of outcomes* include persons with specific skills and operational techniques, there are various thinking processes and practices, able to solve technical problems along with using the manual, and able to control the operation to achieve the correct conclusion. • *Qualification pathways* include being qualified to qualify for Level 4 or a relevant professional qualification, having experience to take care of the elderly for at least four years, or have passed the training course test, and performed work in providing care for the elderly for at least four years. • *Performance* includes effectively able to assess the emotional state of the elderly, promoting the elderly to have interaction between people and society, preventing accidents that will occur to the elderly effectively, maintaining hygienic health of the elderly, correctly linking family and caring for the elderly when emergencies occur, and assessing the physical and mental condition of the elderly with effective reports.

2.5. Challenges in human resource management for elderly care in Thailand

There are several challenges in the human resource management for elderly care in Thailand. First, the lack of availability of caregivers is the main concern in elderly care in Thailand. The government needs to fully pay attention to attracting human resources or caregiver candidates from inside or outside the country.

Second, there is an unequal distribution of health personnel in the Bangkok Metropolis and other provinces amongst community health centres in urban and rural areas. In addition, the shortage of healthcare personnel still remains.

Third, a lack of availability and sufficient numbers of skilled care assistants in Thailand remains. Therefore, training is needed.

Fourth, currently, there is no clear model for long-term care in Thailand, especially regarding the standard of care, training curriculum, staffing norms, and the evaluation of services.

Last, no assessment tool can be found for human resources in long-term care institutions for older persons.

3. Elderly care facilities in Thailand

3.1. Social welfare development centres for older persons

The Ministry of Social Development and Human Security (MSDHS) operates 12 centres across the country, in Bangkok, Chon Buri, Chiang Mai, Ayuthaya, Buri Ram, Phuket, Yala, Pathum Thani, Lam Pang, Songkhla, Nakhon Phanom, and Khon Kaen. Besides these centres operated by the central government, there are more facilities for older people provided at the local government level as well.

They divide older persons into three groups when they select the clients who can be accommodated: A) those who can walk and move by themselves, B) those who need some assistance to move, and C) those who are bedridden. In Bangkok, at the Ban Bang Khae Social Welfare Development Centre for Older Persons, there are 118 persons in Group A, 39 persons in Group B, and 80 persons in Group C. In Chiang Mai, at the Thammapakon

Centre, there are 97 persons in Groups A and B, and 27 persons in Group C.[5]

Older persons who are over 60 years old can use the centres, but usually most are over 70 years old. Group A can enjoy singing, playing games, and so on according to the time schedule. In the 'Friends Support Friends' programme, people in Group A visit the neighbouring communities to support older persons in the community. Even within the centres, the clients who can support others often provide some level of support.

They are operated by the government and, at the same time, some foundations support these centres. Donations from companies and individuals are also an important source of funding for the activities. Recently, as part of many companies' social responsibility (CSR) programmes, they donate money or perform voluntary work at these centres.

Usually the price is free for the clients who are older people. But in Bangkok, people who belong to Groups A and B and wish to stay in larger rooms with some private space have to pay B1,500 per month plus the water/electricity fee.

The centres not only accommodate older people but also approach communities to support older persons in the community. Sometimes, they support the reform of houses, such as the toilet facilities, to make them user-friendly for older persons.

In Chiang Mai, the Thammapakon Centre covers seven provinces and accepts 124 older persons from seven provinces, with 40 staff, including eight trained caregivers. In Bangkok, there are almost 40 caregivers working, with five to six trained caregivers for each group of 30–40 persons.

All caregivers in the centres are considered competent as they have been trained through formal and non-formal education. However, although the Social Welfare Development Centres are working well, the classification of the clients is still unclear. The ratio between caregivers and clients (5–6 clients per 1 caregiver), which leads to a high workload amongst caregivers, causing them stress and depression. It is recommended to increase the number of caregivers and arrange for better classification of clients based on their care needs.

[5] As of the end of 2018 (Annual Report on Ban Bang Khae and interviews with the staff at the centres in November 2018).

3.2. Private nursing homes and home care services

Even though home care by family members is common in Thailand, the role of the nursing home and various elderly care facilities is also beginning to become important due to the progress of ageing, the change of family composition, and so on. Of course, the majority still believes that care by the family is the best option; therefore, not only nursing homes but also sending trained caregivers to provide support inside the home is one of the options. When older people suffer a severe sickness, before returning home from the big hospitals, rehabilitation facilities can provide the necessary information, knowledge, or skills for them to live at home. These facilities and services are still at the initial stage but have an important role in elderly care in Thailand.

Gradually, some private elderly care facilities have been appearing within and in the suburbs of Bangkok in recent years, but there is no data available. Here, we introduce five nursing homes and facilities for elderly care in Bangkok: P (established in 1993), Q (established in 2012), R (established in 2003 and opened a nursing home in 2011), S (established in 2018), and T (established in 2016). S and T focus more on rehabilitation by cooperating with the hospitals, and they provide training to improve the rehabilitation skills of the patients and families before the patients return home.

The founder of P and Q are nurses. The founder of P noticed the importance of care for older persons in the early 1990s and decided to share her professional skills in care for older persons. The founder of Q also decided to start the home in order to utilise her professional skills when she saw the difficulties her neighbours were facing in taking care of people with dementia. R is a Japanese company that decided to open a nursing home to introduce Japanese nursing care quality. Except for P, all these facilities opened in the 2010s.

The prices vary by nursing home/facility. B30,000–50,000 per month appears to be the standard price for such services, but the price can be more expensive if extra services are required. Considering that the average monthly salary for a worker is B12,570 and B51,088 for a manager in the manufacturing sector in Thailand,[6] such nursing home fees are expensive for the general public. They are still luxury services targeting wealthier families.

[6] Based on the investment climate survey by JETRO (JETRO website).

At least one or more registered nurses stay in each facility. Trained caregivers work for each room or each floor, one to four clients per caregiver, depending on the situation of the clients. Caregivers often come from the north or north-eastern regions of Thailand, with only a few from Bangkok. They graduate from the nursing aid schools near their hometowns or in Bangkok after high school and then get jobs in nursing homes and hospitals. In some facilities, there are some caregivers who have worked at the same place for several years, and they find a way forward to gain more skills as practical nurses or registered nurses.[7] However, some caregivers tend to quit quickly, within a few weeks, due to low remuneration because of the low minimum wage levels, or because they find more attractive or easier jobs. The demand for trained caregivers is always high. Therefore, many of the nursing homes or elderly care facilities have started nursing aid schools to meet the demand for their own sustainably and to share their professional knowledge with the people who really need it. P, Q, R, and T have their own training schools.

3.3. Facilities for foreigners

a) Facilities in Chiang Mai

The elderly care industry in Thailand is not only for the Thai elderly but is also open for older persons from other Asian and Western countries, in the context of the promotion of medical tourism and long-term stayers. There are assisted living facilities for seniors in Chiang Mai, such as the Care Resort Chiang Mai, Dok Kaew Gardens, Vivo Bene Village, Baan Meesuk; in Pattaya, the Mabprachan Garden Resort, Namthip Nursing Home Pattaya, Zbreeze Elderly Resort, and Golden Years Hospital that support the elderly (Zander, 2017). Costs for home care vary greatly. Fulltime caregivers without a nursing degree can be hired for as little as B8,000–10,000 per month (US$225–280) in Chiang Mai. Studies conducted in other countries show that health care and long-term costs are related to factors like age, gender, comorbidity, admission, dependence on personal ADL, living arrangements, and health status, amongst others (Kehusmaa et al., 2012; Khongboon and Pongpanich, 2018; Zyaambo et al., 2012).

An example of a senior assisted living facility is Vivo Bene Village, which was awarded the highest score by the Thai Ministry of Tourism for providing long-term care for both

[7] Practical nurses have one year of training and hold an official licence, while registered nurses are who have finished a bachelor of nursing science and hold an official license.

foreigners and Thai people in Thailand. The levels of care provided by this institution are grouped into four: 1) essential care (minimal assistance, such as for getting dressed and bathing; the guests are able to organise their own schedules), 2) comfort care (assistance with various tasks throughout the day but able to manage simple aspects without difficulty), 3) intensive care (full hands-on assistance in every aspect of daily living from waking until sleeping), 4) permanent care (similar to intensive care with support 24 hours a day). The cost varies depending on the level of care, starting from B47,500 (US$1,435) per 30 nights. This institution seems to have the most luxurious facilities in Chiang Mai.[8]

In addition, it provides services for foreign elderly, mainly Swiss and German guests, as well as those from the United States, the United Kingdom, and so on. They have a staff of 40 nurses and nurse aide/caregivers to take care of the elderly amongst the 100 staff. In Chiang Mai, there are more qualified hospitals – therefore, if the patients need medical treatment, they can go to hospital with support from the resort hotel. Medical treatment is not the only focus; there are also attractive sightseeing places with fresh air and nice facilities that allow families to visit comfortably.

Basically, all caregivers are well trained, and the training for caregivers for foreign clients is the same as the training for caregivers for Thai clients. However, the caregivers for foreigners have to learn foreign languages. Therefore, they have to attend additional language training courses, such as for English, German, and Japanese.

b) Challenges for foreign elderly

More foreign elderly have decided to stay longer or live in Chiang Mai because of the relatively lower living expenses and hospitality in Chiang Mai. Japanese older people have also shown interest long-stay options or migration to Chiang Mai after retirement. As of 2017, more than 3,200 Japanese live in Chiang Mai, and half are over 60 years old. There are several clubs or associations to help the older Japanese in Thailand to enjoy their second lives.

[8] Vivo Bene (https://www.vivobene.ch/documents/vivobene-price-list-usd-thb.pdf) accessed on 5 May 2019.

However, every year, around 20–25 Japanese die in the northern region.[9] Some people abandon their family networks in Japan, making it difficult to contact their families to consult on funeral arrangements and sorting through belongings and so on in the event of death. For those who are relatively younger and healthier, staying long term in Chiang Mai can be very nice, with the hospitality and good weather and so on. But when they become much older and suffer sickness, including dementia or other serious diseases that need long-term care (after starting to live in Thailand), and if they are not prepared enough including the health insurance, they may face more difficulties.

4. Whether to work within the country or abroad

Thailand used to be a workers' sending country. However, now, fewer people are interested in working abroad and in the field of care work. The majority of nurses in Thailand mainly focus only on working within the country and are not interested in working abroad. As for caregivers, it is the same situation; although there are some opportunities to work abroad. This is mainly because of the language and family barriers they face. The Ministry of Public Health and Thai Nursing and Midwifery Council does not push its human resources to work abroad; nor does it force them to stay within Thailand. However, the Ministry of Public Health and Nursing Council expects that nurses and caregivers should stay in the country, as the shortage of health personnel still exists.

Additionally, in response to the health personnel shortage, Thailand accepts workers from neighbouring countries but it is not open to foreign care workers. In response to the promotion of medical tourism and the growing demand for English-speaking staff, Filipino staff who have a nursing license in the Philippines can be found in hospitals and care facilities of Thailand, but they are not allowed to work as registered nurses (Wongboonsin et al., 2017). As for the caregivers, it is also prohibited for foreign caregivers to work in Thai nursing homes. Some domestic workers from the neighbouring countries may support the domestic work in nursing homes or individual houses, but working as a caregiver is illegal at present.

On the other hand, the option of working abroad is further discussed amongst nursing students in nursing education rather than nurses in hospitals or healthcare centres. For

[9] *Nishinippon Shimbun*, 2017. Article, 16 Oct. https://www.nishinippon.co.jp/feature/attention/article/378051/ (accessed 27 February 2019).

instance, working as a 'technical intern trainee' caregiver in Japan is one option for nursing aide students that has been available since November 2017. In September 2018, the first group of Thai caregivers arrived in Japan. They are expected to work in nursing homes in Japan for three years.

For students studying at nurse aide schools in the provinces, working abroad is still an attractive option because of the better salary and the greater opportunities to acquire more advanced skills. For schools that face difficulties in attracting students, working abroad can be a good advertisement.

There are some nurse aide schools in Chiang Mai that provide Japanese language courses for students who wish to work in Japan after their training courses. Nurse aide schools X, Y, and Z are amongst them. Nurse aide school Z and another school W provide German language courses. The students learn the language in addition to the knowledge and skills for providing care for older people.

Since the establishment of the schools, schools X, Y, and Z have collaborated with counterparts in Japan. Their counterparts are always companies that run an elderly care business or a related business in Japan. They visit the schools regularly to teach the students and check the curriculum and so on.

Most students start studying in the nursing aid course to get a job sooner. Generally, they earn B9,000 per month in the initial year, or even higher if they work longer hours. However, if they work in Japan, they can receive a higher salary than in Thailand. This attracts students to successfully complete the nurse aide course after high school level education.

To work in Japan, they need to learn the Japanese language and then pass the exam in the Japanese language at level N3 or N4[10] before leaving Thailand. At school X, this takes an extra nine months after the normal course schedule for the caregivers. Therefore, not all the students who are interested can join the course. Sometimes, they, or their Japanese counterparts, prepare a scholarship for students who are from poor families or provide free accommodation in the school's buildings.

[10] The level N3 means 'the ability to understand Japanese used in everyday situations to a certain degree', and the level N4 means 'the ability to understand basic Japanese' (https://www.jlpt.jp/e/about/levelsummary.html, accessed on 25 September 2019).

Japan started to receive caregivers from Thailand in 2018; therefore, it is not possible to evaluate the impact on the human resource development of caregivers in Thailand yet. However, it can provide another option for caregivers or caregiver students in Thailand and, at the same time, the counterparts in Japan can seek opportunities in the care business in both Japan and Chiang Mai. It is also necessary to carefully watch the career path of the returning trainees over the long term, because they may also find better-paid jobs not as caregivers if the working environment for caregivers has not improved much in Thailand.

5. Conclusion

The ageing society in Thailand is not a future issue but a current challenge. Other ASEAN Member States can learn from the experience of Thailand, because Thailand is progressing far ahead in terms of population ageing compared to other ASEAN Member States, except Singapore.

The Thai Government has been preparing for the situation for more than 30 years, but still many things are at an early stage. Generally, community/families are the important actors in care for older persons. This trend is still common for the majority of Thai people. However, the pace of population ageing is accelerating. The older population is growing all over the country. It is particularly more serious in the north-eastern region. Therefore, the training of caregivers is important for taking care of older persons and to support them in their families and communities. There has also started to appear a number of higher-quality nursing homes in and around Bangkok. Because of these changes, the demand for trained caregivers is growing. Currently, more nursing aid schools have started to train caregivers. Standard training programmes have to be prepared by the relevant institutions, and caregiver certification is necessary as a professional qualification to ensure the high quality of care.

Population ageing is happening not only in Thailand but also in many countries in Asia and all over the world. Some Asian and Western countries have started to expect a supply of caregivers from Thailand, or some older people from other countries will come to live in Thailand (especially Chiang Mai) long term. There are various challenges and opportunities in caring for older persons. Thailand should manage its own elderly population and, at the same time, consider this regional/world-wide issue together with the regional and international communities.

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