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Agents of Care Technology Transfer

Trends and Challenges of Migration Care Workers Across Borders

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List of Abbreviations and Acronyms

ADL	Activities of Daily Living
AHWIN	Asian Health and Welfare Initiative
ASEAN	Association of Southeast Asian Nations
ASLI	Asosiasi Senior Living Indonesia
BNSP	Badan Nasional Sertifikasi Profesi (National Agency for Professional Certification)
BPS	Badan Pusat Statistik (Central Statistical Office), Government of Indonesia
COPD	Chronic Obstructive Pulmonary Disease
DM	Diabetes Mellitus
EPA	Economic Partnership Agreement
FCW	Foreign Care Worker
FY	Fiscal Year
JICWELS	Japan International Corporation of Welfare Services
JLPT	Japanese-Language Proficiency Test
IST	International Students
ILO	International Labour Organization
IOM	International Organization for Migration
QOL	Quality of Life
LTC	Long-term Care
LTCI	Long-term Care Insurance
LTCIA	Long-term Care Insurance Act
METI	Ministry of Economy, Trade and Industry, Government of Japan
MDGs	Millennium Development Goals
MHLW	Ministry of Health, Labour and Welfare, Government of Japan
MOFA	Ministry of Foreign Affairs, Government of Japan

MOJ	Ministry of Justice
NBE	National Board Examination
OTIT	Organization for Technical Internship Training
PUSKESMAS	<i>Pusat Kesehatan Masyarakat</i> (Community Health Center)
POSYANDU	<i>Pos Pelayanan Terpadu</i> (Integrated Service Post)
POSBINDU	<i>Pos Binaan Terpadu</i> (Integrated Development Post)
RISKESDAS	<i>Riset Kesehatan Dasar</i> (Basic Health Research)
RSA	Registered Supporting Agency
UN	United Nations
URINDO	University of Respati Indonesia
SDGs	Sustainable Development Goals
SNS	Social Network Service
SSW	Specified Skilled Worker
TITP	Technical Internship Trainee Program
WHO	World Health Organization

Introduction

Yuko O. Hirano

Population ageing has emerged as a distinct demographic feature. According to World Population Prospects data in 2015, the number of older people (those aged 60 years or over) has increased substantially in recent years in most countries and regions. The number of older people is expected to more than double by 2050 and more than triple by 2100, rising from 962 million globally in 2017 to 2.1 billion in 2050 and 3.1 billion in 2100 (United Nations Department of Economic and Social Affairs, 2019). Globally, the population aged 60 or over is growing faster than all younger age groups. This population growth is projected to increase in the coming decades, and this demographic shift is faced by every country in the world that is experiencing growth in the number and proportion of older people in their populations.

The ageing situation in Japan, which is experiencing a 'super-aged society', is particularly crucial. The population older than 65 years comprises more than 35 million people, making up 28.1% of the total population of the country as of 2018 (Cabinet Office, n.d.), and the aged population in Japan is projected to increase to about 36.77 million by 2025 and 39.35 million by 2042. Meanwhile, the total population of Japan started to decline in 2010. The decrease in population is particularly large in the population aged between 15 and 64 years old, which peaked at 87.16 million in 1995 and drastically decreased to 75.96 million in 2017, and is expected to continue decreasing. Under these circumstances, the ageing ratio, that is, the proportion older than 65, is expected to rise to 38.4% in 2065. The figure indicates that the population ratio of those older than 65 to those between 15 to 65 will be 1:1.3 by then.

Under such circumstances, Japan is expected to have a shortage of workers, particularly those engaged in care work. Japan's Ministry of Economy, Trade and Industry (METI, 2018) estimates that the deficit of care workers in Japan will reach 680,000 by 2035. To cope with this, METI suggests 1) introducing information technology or machines that support care workers, i.e. care-assisting robots, and 2) recruiting a potential care workforce, i.e. older people who are healthy enough to engage in care, to compensate for the shortage of the care workforce in the long run (METI, 2016). On the other hand, there are obviously imminent needs for manpower in care facilities. According to a survey conducted by the Kaigo Rodo Antei Center (2015), nearly 60% of the care facilities in Japan said they felt the shortage of the care workforce a little/much/very much. In addition, more than 70% of the respondents to the survey answered that the shortage of manpower was due to the difficulty in recruiting the workforce.

To meet the urgent needs of manpower, many care facilities in Japan are now trying to recruit manpower not only domestically but also from abroad. The phenomenon of the global migration of care workers, which has been experienced in the past even in Asia, has been accelerating in Japan since 2008 through Economic Partnership Agreements (EPAs) signed between Japan and other Asian countries, starting with the Japan-Indonesia Economic

Partnership Agreement (2008), following by the Japan-Philippines Economic Partnership Agreement (2009) and the Japan-Viet Nam Economic Partnership Agreement (2014). Following the EPAs, Japan started to create several other categories of status of residence in Japan to accept more foreign care workers, such as technical internship (TITP), international student (IST), and specified skilled worker (SSW). This was a drastic change in Japan's labour market policy in order to open up the market for foreign care workers and cope with the serious shortage of care workers in Japan's domestic labour market.

However, regardless of how many foreign workers enter Japan to work at care facilities, the shortage of care workers is yet to be resolved. This can be proved by the turnover ratio of the certified care workers who entered Japan under the above-mentioned bilateral agreements. Under the EPA programmes, care workers can continue working in Japan if they pass a national examination for certified care workers after several years of working as candidates in Japan. According to the Ministry of Health, Labour and Welfare (MHLW, 2020), 340 people, or 33.4% of those who obtained a national licence for certified care workers in Japan (a total of 1,017 people), were no longer working as certified care workers under an EPA in 2020. In other words, even after the workers obtain a national licence as a certified care worker that enables them to stay in Japan without limitations on the number of working visa renewals, many decide to quit their jobs in Japan. Unless Japan starts investigating the cause of this high turnover rate, less-skilled care workers, not only Japanese but also foreign care workers, may enter to undertake the work. Therefore, it is time for Japan to focus on the fundamental issues that are resulting in the high turnover rate in care industries regardless of the nationality of the care workers. The question of how to acquire a larger care workforce must be discussed by asking how to attract a greater care workforce in the care setting.

Meanwhile, the Asian Health and Welfare Initiative (AHWIN), which was launched by the Japanese government in 2016, stresses Japan's contribution to other Asian countries through Japan's lessons on how to cope with the issues of an aged society from decades of past experience, such as Japan's long-term care (LTC) system. Care work, however, is diverse depending on the cultural and societal settings; therefore, Japan must first carefully observe the current conditions in care work settings through a multi-faceted, evidence-based approach to identify the pros and cons of Japan's care work. This is the primary step that Japan should take before sharing Japan's LTC system with other Asian countries.

To establish an LTC system, the World Health Organization (2017) has identified three approaches: 1) establishing the foundations necessary for a system of LTC, 2) building and maintaining a sustainable and appropriately trained workforce, and 3) ensuring the quality of LTC. WHO also points out that to support these approaches, it is necessary to 1) develop guidelines providing evidence-based guidance on how to develop, expand, and improve the quality of LTC services with a focus on less-resourced settings; 2) provide technical assistance and support to countries that are introducing and expanding LTC services; and 3) develop tools and training packages to strengthen formal and informal care workers.

The purpose of this project is to show the models of promoting the transfer of knowledge and skills of LTC from the destination countries (Japan) to the sending countries (Indonesia) of care workers. Taking the above-mentioned WHO approaches into consideration, we tried

to obtain empirical data as a first step. In this report, first, we tried to show the difference of the definition of 'care' or LTC between Japan and Indonesia. In Chapter 2, the policies of the Japanese government on migrant care workers are discussed; i.e. the Japanese government has recently expanded its labour market for migrant care workers, but the new migrant care workers' programmes are not designed well for securing an LTC workforce. Chapter 3 discusses the cost of having foreign care workers from an economic perspective. Chapter 4 presents the findings of a study targeting Vietnamese EPA care workers who have already gone back to their home country. In Chapter 5, we focus on oral care, because this is one of the forms of care which supports the fundamental needs of human beings, whereas the acts of providing care, such as what food to prepare for whom and what kind of support to be offered to whom, may vary in accordance with the concept of care of each culture. The human anatomical and physiological function of swallowing food is common, so oral care is an ideal field amongst many care practices, based on which an international standard of care practices is developed. In this chapter, we propose a checklist for oral care practitioners, which is endorsed by experts in both Indonesia and Japan and has potential for international standardisation. We believe such standards are crucial for the promotion of the cross-border circulation of care workers.

After this study, we intend to proceed to the next study, which will aim for the development of a training curriculum based on the proposed oral care checklist. Theoretically, this curriculum can be used both in Indonesia and Japan, so the knowledge and skills achieved through this curriculum can also be utilised in both countries. In this way, we would like to achieve our goal of this series of projects and contribute to the promotion of the effective and efficient circulation of knowledge and LTC skills.

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Chapter 1

Definition of Care in the Asian Context

Susiana Nugraha and Yuko O. Hirano

The issue of an ageing society is not only limited to Japan or Western countries but also affects other Asian countries. Care for the aged is a common issue facing both Japan and the rest of Asia, particularly the issue of enhancing the capacity building of the care workforce. The experience of how Japan, one of the most aged societies in the world, has been dealing with the issues that have risen in the past decades may indicate some solutions for more recently ageing societies.

However, it is widely said in Asian countries that ‘growing old before becoming rich’ is a common phenomenon. In this context, Japan, which has made numerous achievements in developing its economy and establishing a social welfare system before facing the crucial issue of ageing, would not serve as an ideal example for Asian countries. In other words, Asian countries cannot simply adopt Japan’s know-how in care services and human development for themselves.

In this chapter, the research team analyses the uniqueness of the long-term care (LTC) system in Japan in comparison with that of Indonesia. It is essential for Japan, a country that has been receiving many foreign care workers from Indonesia, to understand the care system as well as the capacity building of the sending country so as to efficiently receive the workers and work together with them in Japan in this era of globalisation.

1. *Kaigo*, the concept of LTC in Japan

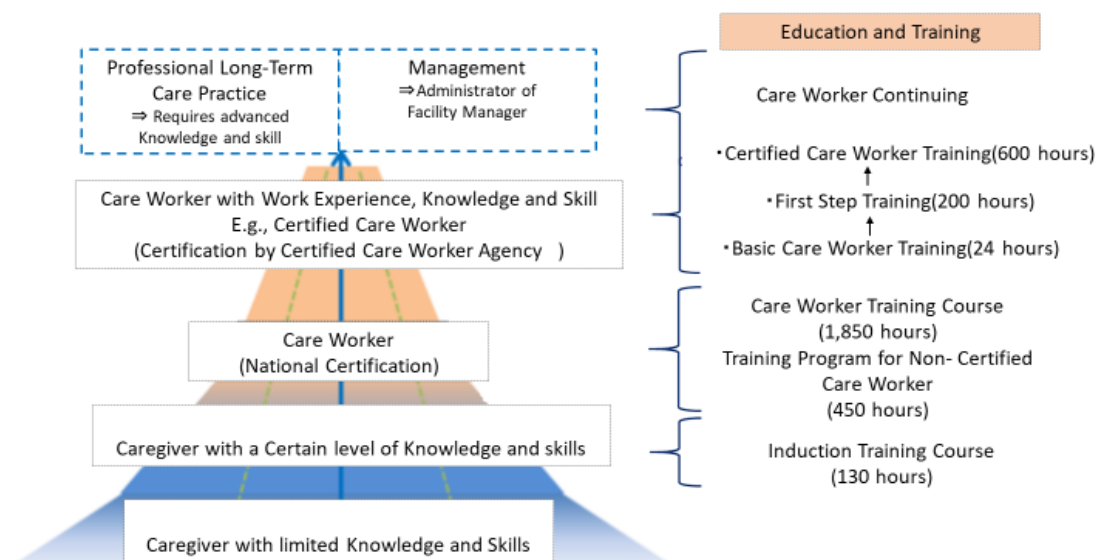
The LTC system in Japan, hereinafter referred to as ‘*kaigo*’, is primarily defined as providing the necessary assistance to aged and disabled people who require help from others in their daily lives. It may be said that one distinct feature of *kaigo* is that assistance is provided at the recipient’s ‘place of daily life’ (Mizuho Information & Research Institute, 2018). This means that whether it is institutional-based care or home-based care, the individual quality of life (QOL) of the client is respected, which underlies their daily living. In this way, *kaigo* can be differentiated from nursing, which is mainly provided in hospitals in the context of medical intervention.

Kaigo work is an essential profession nowadays due to the high overall longevity and the number of older people who are in need of care. This is particularly true since Japan has experienced the transition of the family structure from the extended family to the nuclear family and the movement of women into the workforce. Historically, in Japan, family members, especially women, were engaged in care work as family caregivers as unpaid work. As the family size began shrinking and more women became engaged in income-producing work outside the home, Japanese society saw a change in the social structure where care

work could no longer be covered by family members, and the ‘socialisation of care’ was needed. The socialisation of care, in other words, government policy to ensure professional care for people in need, has created a new profession to compensate for the shortage of family caregivers. The need for personnel that can handle diverse and highly needs for improvement of their qualifications has become necessary to meet the expansion of aged and disabled people’s social welfare needs due to changes in living styles and economic conditions accompanying the declining birth rate and ageing of the population. The need for professionals able to ensure service ethics and quality in light of the rapid expansion of services related to the aged has also become a point of discussion. As a result of these circumstances, the national certification for care workers was created in 1987 (Mizuho Information & Research Institute, 2018). Certified care workers, or *kaigo-fukushi-shi*, have been enhancing their scope of care by performing more invasive, higher quality care, such as sputum suctioning. The Ministry of Health, Labour and Welfare has stipulated that those who undergo special training for sputum suctioning are eligible to practice in care settings, regardless of the certification they have.

The Japanese care worker career path is shown in Figure 1.1. There are many certifications besides *kaigo-fukushi-shi*, a national licence, although the care workers commonly engage in assisting the daily needs of the clients regardless of certification, and no specific difference in function can be observed. For this reason, in this report, we refer to those who are engaged in care work in care facilities in Japan as ‘*kaigo* workers’.

Figure 1.1. Career Path of Care Workers in Japan



Source: Mizuho Information & Research Institute (2018).

2. Features of *kaigo* in Japan

Kaigo workers, as a profession differentiated from family caregivers, have been widely known amongst the Japanese people since the Long-Term Care Insurance Act (LTCIA) came into force in 2000. Under the act, all citizens are required to join the scheme in the month they turn 40 years old and pay an insurance premium. The LTC insurance system is based on the principle of mutual aid, such that the source of funds is 50% public (from taxes), with the remaining 50% financed by insurance premiums.

The LTC services can be received by people over 65 years old when in need of support or care regardless of the cause. For people between 40 and 64 years old, services are available when in need of support or care due to illnesses associated with ageing, such as terminal cancer and rheumatoid arthritis. When LTC becomes necessary, the insured can apply through the local municipal government to obtain an authorised certification of eligibility for care ranked from one to five under the Long-term Care Insurance Act. Through this process, they are authorised as a beneficiary of the services provided by the LTC insurance system, enabling them to make use of such services in accordance with the care plan that is created for every beneficiary through the discussion between the care manager and beneficiary. During the process of developing care plans, the autonomy of the beneficiaries must be respected, and caps are set on the LTC services provided to the beneficiaries in accordance with their care or support levels.

LTC requires practices based on specialised knowledge, techniques, and ethics, which can affect the QOL of the clients. Therefore, *kaigo* can be characterised by the following points: First, it requires an awareness of the human rights of the clients. It is necessary to respect the individual client, even when needing support from others. Second, it requires LTC expertise. Such expertise, including careful observation and communication, requires collecting the clients' information so as to improve the QOL of each client during care practices. Third, it requires the perspective of professional LTC implemented by evidence-based practice. Currently, in Japan, evidence-based LTC is provided by applying a four-stage process to support the care recipient's daily life: 1) initial assessment: information collection to identify the key issues; 2) developing a care plan; 3) implementation of the care plan; and 4) evaluation to confirm effectiveness. These features are necessary when the *kaigo* workers work as a collaborative team of professionals with various types of expertise, such as doctors, nurses, occupational therapists, and psychical therapists.

3. LTC: An emerging issue in Indonesia

According to Ms. Amano, a member of the research team, some *kaigo* workers from Asian countries were told by their Japanese supervisors, 'The clients of the care facilities are not your grandfathers or grandmothers. They are customers!', whilst the *kaigo* workers tried to provide services to the clients as if they were their grandfathers and grandmothers. It can be interpreted that the Japanese supervisors were trying to strengthen their professionalism by differentiating their practices from that of family caregivers who are laypersons. However, such orders from Japanese supervisors sometimes confused the *kaigo* workers from abroad,

since in many Asian countries, care work is provided only by family or community members.

In order for Japanese care institutions to better understand the care systems of the countries of origin of foreign care workers, the authors of this chapter focused on the feature of LTC in Indonesia, which is one of the countries that have sent the greatest numbers of care workers to Japan.

3.1. The aged population in Indonesia

Indonesia's older population grew at an unprecedented rate during 1990–2020, with an increase in life expectancy from 66.7 years to 70.5 years. Thus, Indonesia entered the stage of having an ageing population marked by the percentage of older people (age 60 and above) reaching 10% of the population in 2020. Globally, Indonesia ranks fourth in population size, whilst its aged population size ranks 10th. The number of older people in Indonesia was more than 25 million in 2020 and in 2050 is forecast to reach 80 million (28.68%) Badan Pusat Statistik (2020).

Older people are more likely to have physical, mental, spiritual, economic, and social problems. Chronic ailments and frailty are associated with physical and mental deterioration and lead to the emergence of the need for LTC for older people. The results of RISKESDAS 2018 (Basic Health Research 2018) showed that many older people in Indonesia have chronic ailments, which can be strongly related to the prognosis of their activities of daily living (ADL), such as hypertension, osteoarthritis, dental-oral problems, chronic obstructive pulmonary disease (COPD), and diabetes mellitus (DM) (Ministry of Health of the Republic of Indonesia, 2018). The functional capacity of an older person is defined as their ability to perform at least one item amongst several components of ADL. The results showed that approximately 51% of people aged 60 or above had a disability, with the trend that older age groups had higher rates of disability. Older people with mild disabilities made up around 51% for those aged 55–64 years, and 62% for those aged 65 and above, whilst severe disability affects about 7% of those aged 55–64 years, rising to 10% at 65–74 years and 22% at 75 years and above (Ministry of Health of the Republic of Indonesia, 2016).

3.2. Geriatric services provided in Indonesia

LTC in Indonesia is referred to as *Perawatan Jangka Panjang* (PJP), which is stipulated by the Ministry of Health under the Decree of the Ministry of Health No. 67 Tahun 2015 on older adult services in public health care (Kemenkes, 2015). Furthermore, this ministerial regulation is described in the long-term care manual guidebook. The long-term care concept applied in Indonesia is adopted from the *Global Strategy and Action Plan on Ageing and Health* stipulated by the World Health Organization (WHO, 2017) [6]. This strategy provides a political mandate for the action that is required to ensure that everyone has the opportunity to experience both a long and healthy life. Extensive consultations across countries and regions, civil society, and other non-state actors contributed to this first ever strategy on ageing and health.

The strategy starts from an assumption that ageing is a valuable, if often challenging, process. It considers that it is good to get old and that society is better off for having older populations. At the same time, it acknowledges that many older people will experience very significant losses, whether of physical or cognitive capacity or of family, friends, and the roles they had earlier in life. Some of these losses can be avoided with appropriate care by caregivers. Family, as informal caregivers, and also professional caregivers (in nursing homes) need to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her preferences, with the greatest possible degrees of independence, autonomy, participation, personal fulfilment, and humanity.

Wherever LTC is provided at home, in communities or within institutions, the goals of LTC should be to maintain a level of functional ability in older people with, or at high risk of, significant losses of capacity, to respect their intentions to keep their healthy status and wellbeing and to ensure older people's human rights and dignity.

Geriatric services have an important role in the challenges to achieve these goals. Access to geriatric services of good quality should be guaranteed to every older person regardless their socio-economic status. In addition, geriatric services must be carried out through an interdisciplinary approach by various professionals, such as doctors, nurses, and caregivers working in an integrated geriatric team. We believe such a multi-professional, cooperative approach is indispensable for the development of geriatric medicine so that various advances in science and technology in the field of geriatric services can be accommodated in practices.

There are three types of geriatric services in Indonesia. First is the *puskesmas*-based geriatric service. Health centres, called *puskesmas*, and private practitioners support community-based geriatric services. In this service, the community is expected to participate in the control of the health status of older people, and the community members are encouraged to undergo training and acquire sufficient knowledge for such purposes. Training programmes for the community members take place in various ways, such as through lectures, symposia, workshops, and counselling. Trained community members, such as health volunteers, monitor the health conditions of older people in their communities and convey the existing problems to the *puskesmas*. Second, geriatric services are provided by *puskesmas* in close collaboration with hospitals. In this system, public hospitals have the responsibility to provide geriatric services to elderly residents in their assigned areas, either directly or indirectly. Indirect services are provided by *puskesmas* in the form of training through workshops, symposiums, and lectures to health workers or laypeople for the purpose of the 'transfer of knowledge'. *Puskesmas* provide basic geriatric services, whilst hospitals are considered as referral centres that accept patients from *puskesmas*. The *puskesmas* is the leading unit in providing services to the community and acting as a consultant for health services for older people in the community, so elderly patients who were previously treated or received hospital services can be supervised by *puskesmas* after returning to the community. Activities at the *puskesmas* include simple promotive, preventive, and curative efforts in accordance with the Guidelines for Elderly Community Health Centers for Health Officers. *Puskesmas* function as extensions of hospitals, so it is encouraged that guidance is provided by hospitals to *puskesmas* in the responsible areas in the form of reciprocal referral activities. Third is the

hospital-based geriatric service. In this service, geriatric services are provided in hospitals in an integrated manner. Hospitals provide various services for the elderly, ranging from simple services in the form of an elderly polyclinic, to more advanced services, such as acute wards, day hospitals, chronic wards and/or nursing homes. Besides these, mental hospitals also provide mental health services for elderly patients with the same pattern. At this level, conjoint care should be carried out between the geriatric unit of the public hospital and the psychogeriatric unit of a mental hospital, especially to treat people with physical disorders with psychiatric disorders.

3.3. Outreach geriatric services provided by *puskesmas*

Geriatric services provided by *puskesmas* are not limited to the activities inside the institutions. There are several outreach activities for older people, such as; 1) geriatric services at *posyandu/posbindu* (integrated services post for the elderly), 2) care programmes for older people at home (home care), and 3) geriatric services at elderly homes established by social institutions (e.g. *Panti Werdha*/Elderly Home).

3.4. The establishment of certification system for caregivers in Indonesia

The concept of a caregiver is not commonly understood as an occupational category with expertise in Indonesia. Thus, caregivers are recognised as a similar category to domestic workers. Caregivers are addressed in several way in the Indonesian language, such as *kader lansia*, *pendanping lansia*, and *pramu lansia* lately.

Meanwhile in 2018, Asosiasi Senior Living Indonesia started a certification programme for caregivers. The category of this certification is called '*Profesi Care Giver*', and this programme was developed by adopting the concept of Japan's induction training course for care workers. The certification is accredited by Badan Nasional Sertifikasi Profesi of the Indonesian government. The introduction of the certification system for caregivers is expected to raise the social status of caregivers in Indonesia, as well as guarantee the quality of care given by them.

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Chapter 2

The State and The Market: Acceptance of Migrant Care Workers Through Multiple Channels

Reiko Ogawa

Discussions on population ageing cannot be separated from those on the migration of care workers. Such discussions are one of the most critical social issues of recent years in Japan. The proportion of people aged 65 years and above in Japan is growing close to 30%. As the ageing population has increased, the labour shortage within the care sector has intensified.¹ In addition, the devastating impact of COVID-19, which has profoundly affected frontline health care workers, may further accelerate the labour shortage in the long-term care sector in the coming years. Without adequate measures and policies to ensure and develop a quality health care workforce, the well-being of frail and dependent older persons, and the career path of migrant workers, will be jeopardised.

There are several channels for labour migrants to enter care work in Japan. The first wave of migrant care workers arrived under the bilateral Economic Partnership Agreements (EPA) with Indonesia, the Philippines, and Viet Nam. Migration was not a major component of those agreements but provided an opportunity to test how the Japanese society would respond to migrant care workers. In 2017, two additional channels were opened: one is that long-term care work was added into the list of occupations of the Technical Internship Trainee Program (TITP), and the other was that international students who graduated from caregiving schools in Japan were granted the residential status of 'long-term care'.² Finally, in 2018, the immigration law was revised to open 14 occupations, including agriculture, construction, and care work, to migrant workers under the status of Specified Skilled Workers (SSW) (Ministry of Foreign Affairs, n.d.).

This study's data are mainly derived from consecutive fieldwork in Japan and Southeast Asia between 2019 and 2020, including interviews with five care facilities that accepted EPA care workers and 14 EPA care workers, including returnees, and eight sending agencies in Viet Nam, Indonesia, and the Philippines. The term 'care work' is synonymous with Japanese '*kaigo*', which refers to old-age care or long-term care but does not include medical intervention.

1. Different channels for the migration of care workers

The number of migrant workers in Japan has been increasing in recent years, and in 2021 it reached 1.7 million, or 2.5% of the total workforce (Ministry of Health, Labour and Welfare, 2022a; Statistics Bureau of Japan, 2022). However, migrants in the field of health and welfare

¹ In 2018, 67.2% of care providers felt the shortage in the care workforce, more than a 10% increase from 56.5% in 2013 (Kaigo Rodo Antei Center, 2013; 2018).

² The national certified care worker exam is exempted for those who graduated by March 2027. They can work for 5 years as certified care workers.

are latecomers and remain at 3.3% of the total migrant workforce, whilst for manufacturing the share is 27%, and for wholesale and retail it is 13.3% (Ministry of Health, Labour and Welfare, 2022a). The four migration channels, namely EPA, TITP, international students studying care work, and SSW, differ in numerous ways in terms of the programmes' aims, applicants' qualifications, Japanese language proficiency levels, terms and conditions of their visa status, cost infrastructure, and migration governance. Table 2.1 illustrates the migration channels that have opened during the past decade.

Table 2.1. Different Channels for Migrants within the Care Sector

Employment model	Economic Partnership Agreements (EPA)	Technical Intern Training Program (TITP)	International Students in Caregiving Schools	Specified Skilled Worker (SSW)
Year of commencement	2008	2017	2017	2019
Legal framework	Bilateral agreements with Indonesia, the Philippines, and Viet Nam	Law on Appropriate Implementation and Protection of Technical Interns; MOU with sending countries	Revised Immigration Control and Refugee Recognition Act	Revised Immigration Control and Refugee Recognition Act; MOU with sending countries
Aim	To facilitate, promote and liberalise trade in goods and services between the parties	Transfer of technology to developing countries	To attract highly skilled human resources	To alleviate the labour shortage
Eligibility to apply	Graduate of nursing schools (Indonesia, the Philippines, Viet Nam) or 4-year university with any major, and obtained an accredited	Above 18 years old, with 1 year of experience stipulation to utilise the skills obtained in Japan, after returning to their home countries	High school graduate	Above 18 years old, no educational requirements. Must pass the test or transfer from TITP, under certain conditions.

	caregiver licence (Philippines)			
Japanese language training and level required at the time of entry	Approximately 1-year free Japanese language training. For Viet Nam, JLPT Level 3 is required.	Approximately JLPT Level 4	Ideally, JLPT Level 2, but this depends on the school's admission policy	Japanese language test ^a and skill test ^b
Institutional framework	Government and semi-government institutions in the sending and receiving countries oversee recruitment, training, and placement	Privately licensed agencies in the sending and receiving countries oversee recruitment, training, and matching. The Organization for Technical Intern Training (OTIT), an official agency, oversees monitoring and support.	Caregiver schools accept applications often through private agencies	Direct hiring is allowed, and migrants can change their employers
Length of Stay	Four years. Once registered as a nationally certified caregiver, no limitation for extension. If failed, can transfer to SSW.	Three years, extendable for two more years, or may transfer to SSW	No limitation once registered as a nationally certified caregiver	Maximum of 5 years

JLPT = Japanese-Language Proficiency Test.

^a JLPT N4 or higher or Japan Foundation Test for Basic Japanese (JFT-Basic) and Nursing Care Japanese Language Evaluation Test.

^b Nursing Care Skills Evaluation Test.

Source: Ministry of Foreign Affairs (n.d.); Ministry of Health, Labour and Welfare (n.d.); OTIT (n.d.)

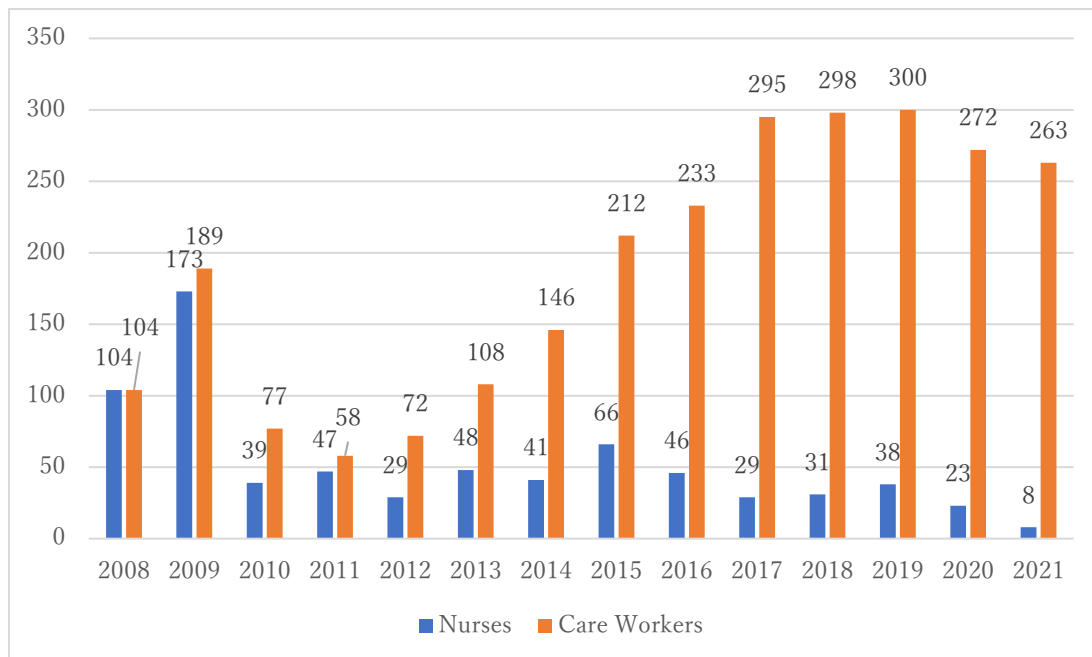
2. Assessment of EPAs after a 10-year period

Since its inception in 2008, a small number of migrant nurses and care workers were accepted not under the migration policy but as an attachment to the bilateral free trade agreement. The EPAs between Japan and three Southeast Asian countries, namely Indonesia (2008), followed by the Philippines (2009) and Viet Nam (2014), state that nurses and care workers from those countries will work in Japanese hospitals and care facilities as ‘candidates’ for certified nurses and care workers, until they pass the national examination. Under the EPAs, a similar framework has been applied for both occupations.

However, after 10 years, the acceptance of EPA care workers has multiplied, whilst those of nurses has declined, as shown in Figure 2.1. These two occupations are constructed differently in terms of education, career development, and the labour market, so it would be difficult to treat them within the same framework.

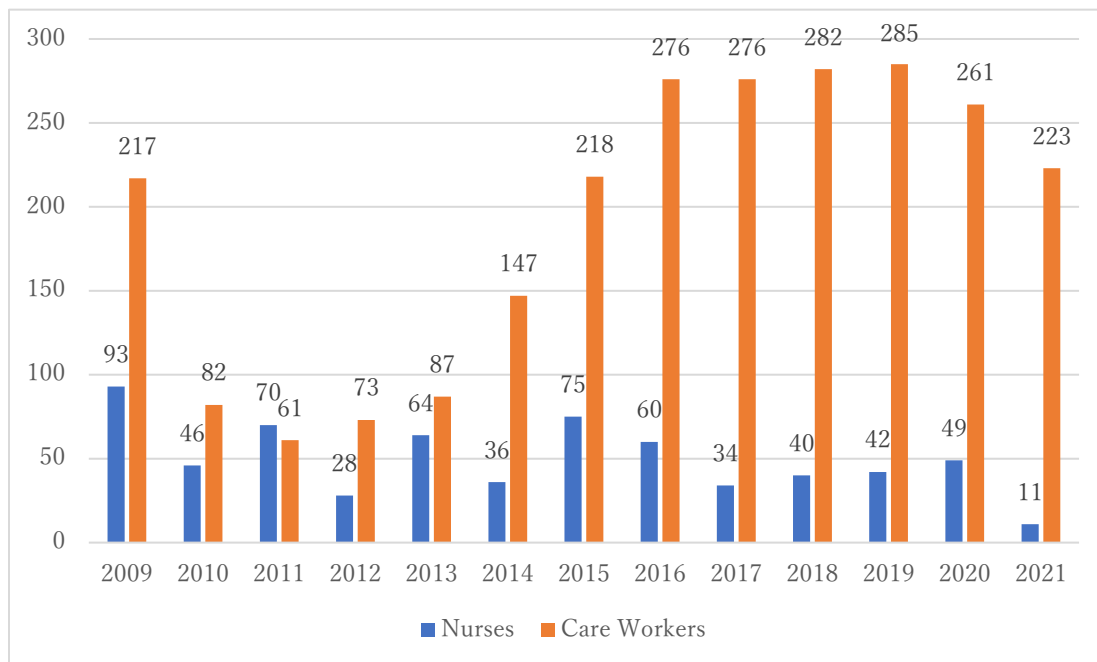
For EPA nurses, the average passing ratio for the national nursing examination has not been higher than 20% in the past 10 years (Ministry of Health, Labour and Welfare, 2019). On the contrary, for EPA care workers, it has never been lower than 33% for the national care workers examination, the highest being 94.8% (Ministry of Health, Labour and Welfare, 2018). Moreover, after 2019, even if an EPA care worker fails the national exam, they can be transferred to SSW and continue to work. This study will focus only on long-term care workers and not on nurses. Figure 2.3 shows that there is far greater demand for migrant care workers than nurses.

Figure 2.1. Number of Indonesian Nurses and Care Workers under the EPA



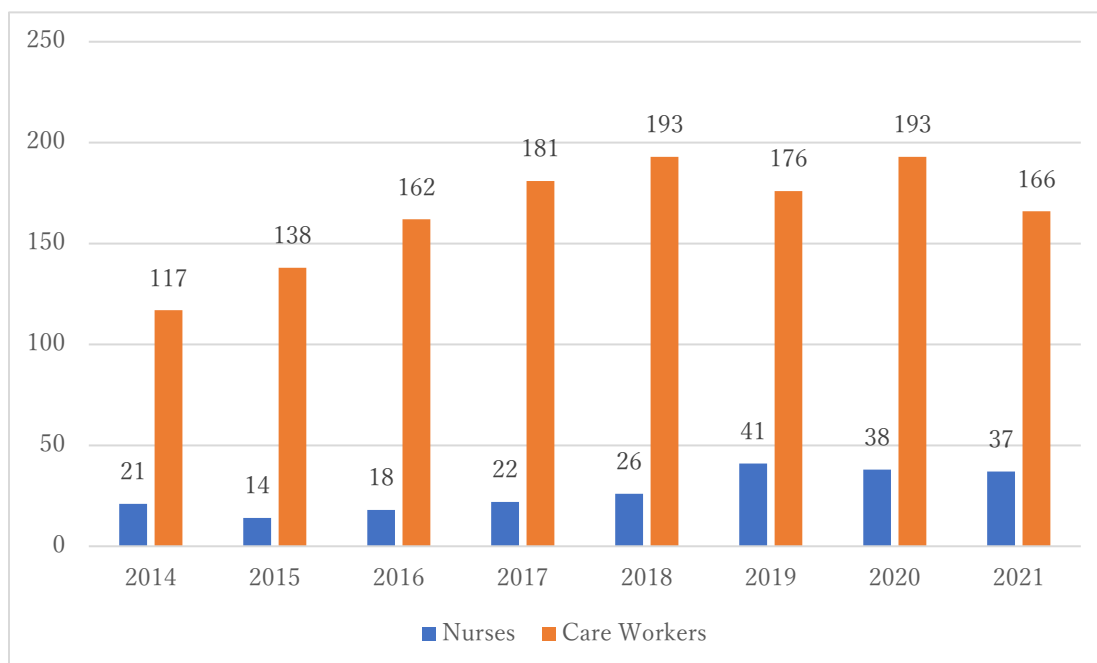
Source: Ministry of Health, Labour and Welfare (n.d.); JICWELS (n.d.).

Figure 2.2. Number of Filipino Nurses and Care Workers under the EPA



Source: Ministry of Health, Labour and Welfare (n.d.); JICWELS (n.d.).

Figure 2.3. Number of Vietnamese Nurses and Care Workers under the EPA



Source: Ministry of Health, Labour and Welfare (n.d.); JICWELS (n.d.).

3. Migration governance of EPAs

EPAs brought care facilities to employ foreign staff for the first time. Nevertheless, according to my field research, the responses from the staff and families have been positive (Ogawa, 2011). Employers and co-workers sincerely appreciated the EPA care workers' contributions, and the workplace has benefited greatly from their presence and attitudes. The positive acceptance of EPA care workers can be attributed to the commitments on migration governance and the preparation in the sending countries, deployment, settlement, and access to citizenship.

Before working in Japan, EPA care workers go through approximately 1 year of Japanese language training, sponsored by the government and employers. The governments or semi-governmental bodies in both the sending countries and Japan serve as mediating agencies in charge of recruiting, matching, monitoring, and supporting migrants in their learning and daily lives.³ After they arrive in Japan, the employers are obliged to support their learning to help them pass the national examination for care workers (*kaigo-fukushi-shi*).⁴ Based on the bilateral agreement, the EPA care worker programme is regulated, and the institutional governance mechanism is transparent compared to the other three market-oriented channels. The high educational background and 1 year of Japanese language training have contributed to the positive evaluations of EPA care workers. The national examination of certified care work also fosters excellent quality of care provided by EPA care workers because it sets a standard of theory and practice in performing care work.

Existing studies on the transnational migration of care workers show how care and domestic work that require close relationships, including physical contact, have created various boundaries and separations based on gender, class, ethnicity, and religion (Anderson, 2000; Parrenas, 2003; Lan, 2006; Anderson and Shutes, 2014; Ogawa et al., 2018). Care and domestic work, as personal services, tend to be forced work under disciplinary regimes and appalling labour conditions. Much of the literature on migration and care is dominated by migrants who work as live-in domestic/care workers in private homes, within a family where power relations manifest. On the other hand, EPA care workers mainly provide institutional care, and home-visit care is limited. In institutional care, working conditions are generally better regulated, more contact exists with outsiders than in private homes, and teamwork amongst staffs is necessary.

After more than 10 years, some EPA certified care workers have already become leaders and managers that supervise Japanese staff, whilst some have even passed the care manager examination. Becoming a certified care worker ensures citizenship, and they can stay for an indefinite period and are free to change employers and bring their families. Currently, more than 500 family members are settled in Japan (E-Stat, 2021) and some have already obtained

³ Japan International Corporation of Welfare Services (JICWELS), Philippines Overseas Employment Administration (POEA), Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia (National Agency for Placement and Protection of Indonesian Migrant Workers), and the Ministry of Labour, Invalids and Social Affairs (DOLAB).

⁴ Until SSW was established, if the EPA candidates failed the exam, they had to return home, but after 2019, EPA care workers can change their residential status to SSW.

permanent residency.

However, on the employers' side, even though care facilities invest in educating EPA care workers, the EPA programme does not guarantee that such care facilities can retain EPA care workers after they acquire the licence. Once EPA care workers become licensed, they are entitled to choose to work at whichever care facility they like, or to return to their home countries and then come back to Japan for work later. For care facilities that provide substantial support for EPA candidates, the risk of candidates resigning, especially after acquiring the national certificate, is significant, as they would lose all the 'investment'.

As a part of the bilateral agreement between the two countries, migration processes are strictly controlled and regulated by the state, and a mediating organisation conducts regular monitoring. Although there are some labour law issues,⁵ human rights violations have not been seen on a large scale in this research, compared to the other privatised labour migration channel.⁶

4. Risks associated with the migration of care workers

Scholarly work on migration has discussed how migrants are socially mediated through a particular system, industry, or infrastructure that conditions the mobility of interlinking technologies, institutions, and actors (Xiang and Lindquist, 2014). The recent opening up of Japan's migratory channels was expanded hand-in-hand with the state regulatory infrastructure and the market-oriented commercial entities who cater to the migrant care workers. This may or may not enhance the capacity of migrants for self-determination and empowerment, but in 2020 and 2021, more than 10,000 migrants from different backgrounds entered care work.⁷ The dependency on migrants will grow for the foreseeable future.⁸

As shown in Table 2.1, these migrants are offered different career prospects and entitlements. Only the EPA care workers are able to receive substantial support for language education and preparation for the national examination as the Japanese government and employers shoulder the costs, and they have access to citizenship and are able to bring their families to Japan. This applies only to EPA care workers, not for other migration channels as follows.

⁵ Through interviews, personal consultations, and cases shared by the civil society, there are issues such as unpaid overtime work, not being allowed to take paid holidays, harassment, pregnancy issues, and limited access to medical care.

⁶ Cases of abuse under the TITP, and against international students in Japan, are reported within the Trafficking in Persons Report (US Department of State, 2019; 2020). The Immigration Bureau admits that violations of labour laws and excessive broker fees paid into the countries of origin of migrants are reasons why TITPs become undocumented (Immigration Service Agency, 2019).

⁷ The number of migrants in social welfare institutions increased from 29,838 in 2020 to 41,189 in 2021 (Ministry of Health, Labour and Welfare, 2022b).

⁸ According to research by the Tokyo Council of Social Welfare, 55.3% of the care facilities in Tokyo are currently employing migrant care workers and 27.5% are planning to employ them in the future (Tokyo Council of Social Welfare, 2021).

4.1. International students

For international students studying at caregiving schools, it costs approximately ¥6 million to complete their schooling, which can take years for students to pay back.⁹ Public and private scholarships support studying and living in Japan, but what is often called a ‘scholarship’ in Japan often needs to be paid back. In some cases,¹⁰ the scholarship provides an incentive to work within the care facility as a part-time worker (up to 28 hours per week) whilst studying, and upon becoming a full-fledged care worker, if the person works for 5 years, they will be exempt from paying back the scholarship.¹¹ Once a student successfully graduates and obtains the certified care worker status, they can stay indefinitely and bring their family to Japan, but their life in Japan begins with debt and is tied to a specific occupation until they pay back the debt.

4.2. Technical internship trainees (TITP)

The TITP was initially conceived as an international cooperation through ‘transferring skills, technologies, or knowledge in Japanese industries to developing countries through human resource development’ (Organization for Technical Intern Training, n.d.). Since TITP workers are tied to contracts for a limited period and cannot change their workplace, they are sometimes described as being at the bottom of the hierarchy in the Japanese labour market (Shipper, 2016).

Except for EPAs, TITP and the other channels are mediated by private recruitment agencies, which may charge exorbitant placement fees. The Philippines has the most progressive law to protect migrants and prohibit the sending agencies from charging placement fees for those who come to Japan (Ogawa and Sadamatsu, 2020). The Vietnamese government has set the maximum amount for the placement fee at US\$3,600/person (Mekong Migration Network, 2019). However, Vietnamese migrants are paying between US\$7,000/person and US\$10,000/person to the sending agencies in this research. In an interview with five undocumented Vietnamese TITP workers who had worked in Chiba, Ibaraki, Aichi, Miyagi, and Kumamoto, they all said they shouldered a debt of approximately ¥1 million, but could only earn around ¥90,000–¥10,000 per month in Japan.¹² Their monthly household income in Viet Nam was between US\$200 and US\$300, and therefore their lives in Japan started with a heavy debt that must be paid back whilst working.¹³ Indonesian TITP workers are also charged US\$4,000 or more, which includes language training for 3 months, accommodation

⁹ This estimate is from the materials presented at the meeting of the Tokyo Council of Social Welfare on 19 February 2019. The cost includes the tuition fee for 3 years (1 year of Japanese language school and 2 years of caregiver school) (¥3,120,000), living expenses (@¥50,000/month x 36 months = ¥1,800,000), dormitory fees (@¥20,000/month x 36 months = ¥720,000), Japanese language education before arrival (¥250,000) and an agency fee (¥120,000). This adds up to ¥6 million.

¹⁰ Osaka Prefecture Guidelines: Acceptance of Foreign Students Under the Status of Residence ‘Nursing Care’ Guidelines, <https://www.pref.osaka.lg.jp/attach/20980/00259484/guidelinedetail.pdf>, p.9.

¹¹ Article 17 of the Labour Standards Act states that it is not permissible to lend money in advance to workers on condition that they work, to force them to work, or to deduct the advance from their monthly wages without permission.

¹² Interviewed during October 2020.

¹³ Research conducted at the sending agencies in Ha Noi during March 2018 and September 2019, and interviews at TITP in Tokyo during August 2020.

for 2 months, document arrangements, airfare, meals, a medical check-up, and predeparture training (Human Rights Working Group, 2020).

The EPA and TITP workers differ not only in their career prospects but also their salaries. EPAs are paid the same as Japanese full-time care workers in principle. On the contrary, the wages of TITP workers are usually suppressed to the minimum wage, which is justified as being because they are under ‘training’,¹⁴ even though their job descriptions might be the same. A wage gap does exist between TITP and Japanese care workers, regardless of their educational backgrounds. Also, the unequal payment is found between EPA and TITP workers, even though they may come from the same educational background.¹⁵

4.3. Specified skilled worker (SSW)

Finally, the SSW system was established in 2019, admitting migrant workers as ‘labourers’ who can be hired directly, with equal payment as Japanese workers and the ability to change employers. We are yet to see whether SSW will enhance the rights of migrants by allowing them to transfer and negotiate their employment conditions. Some sending countries have made it a rule that migrants must go through the sending agencies of their home countries if they want to work as SSWs.¹⁶ Sending agencies and supervising organisations are meant to protect migrants, but according to my study, they often exploit and control them by using the advantages of the power relationship drawn from their transnational connections. SSWs are time bound and are neither in a position to request any support from their employers to become certified care workers nor do they have access to citizenship.

The four channels differ in terms of career prospects, wages, support systems, and residential status, but due to the lack of information in the sending countries, migrants might choose any option available to them without knowing the consequences. A study conducted in Indonesia on the predeparture process of TITPs revealed that Indonesian workers were given little information on the rights and opportunities they are entitled to, or how to proceed if they face problems (Human Rights Working Group, 2020).

5. Ethical recruitment of care workers

The Japanese care labour market has been increasingly sustained by migrants, including those who are in vulnerable positions caused by the state’s migrant policy. COVID-19 also reasserted the importance of well-trained health personnel to sustain the global health care system. The WHO has established the Global Code of Practice on the International Recruitment of Health Personnel to be the core component of bilateral, national, and regional responses to the global shortage of healthcare workers (WHO, 2021). It states the responsibility of the member states to conduct the recruitment of health personnel according to the principles of

¹⁴ Presentation by a social insurance labour consultant at a seminar on how to employ foreign workers, on 10 September 2020, in Chiba.

¹⁵ Interviewed during October 2020.

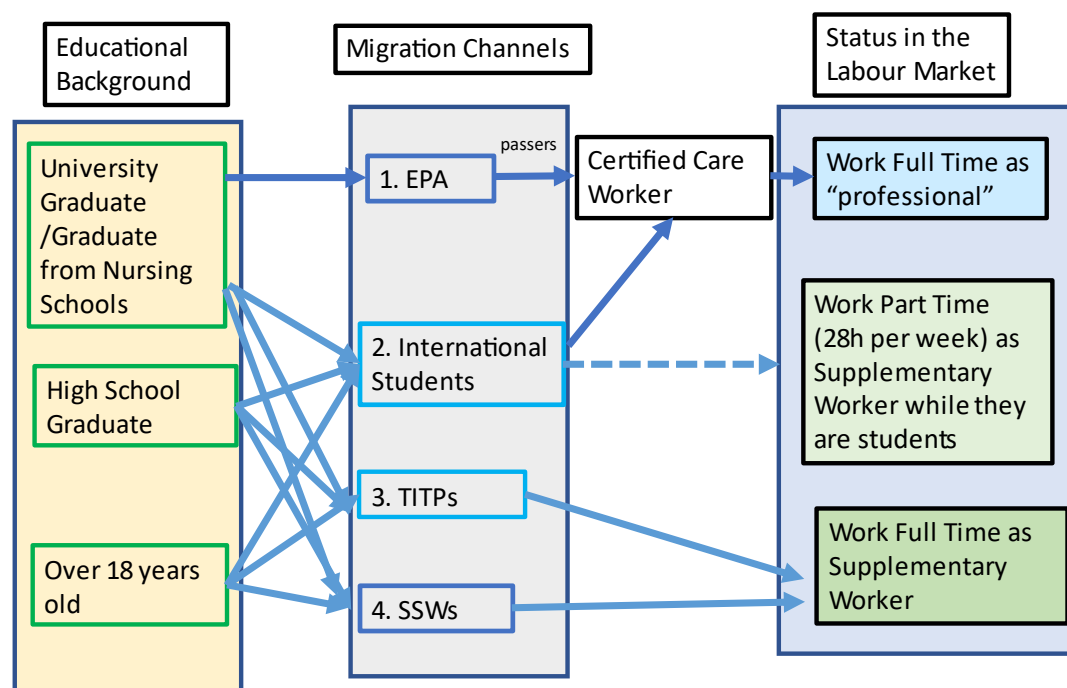
¹⁶ Going through the sending agencies is not a requirement for SSW in Japan; however, some countries do not allow the direct recruitment of workers.

transparency, fairness, and the promotion of sustainability in developing countries. In particular, an important element is 4.4 of the said Code (italics by the author):

4.4 Migrant health personnel should be hired, promoted and remunerated based on *objective criteria*, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered.

Currently, no system exists to evaluate whether migrant care workers are remunerated based on the objective criteria. Figure 2.4 illustrates how different migration channels lead to different outcomes in the labour market.

Figure 2.4. Social Stratification of Migrant Care Workers According to the Entry Channels



Source: Sasaki and Ogawa (2019).

The conditions of migrants highly depend on the channels from which they enter Japan rather than their educational achievements. This can lead to the stratification of migrants and the creation of a segmented care labour market (Sasaki and Ogawa, 2019). The segmented care labour market consists of EPA passers and international students who become certified care workers at the top of the hierarchy with citizenship, and TITP and SSW workers allowed to work for a limited period of time as supplementary workers (Figure 2.4). As such, this can

have a detrimental effect on the care labour market and hinder long-term prospects of human resource development for both care facilities and migrants in envisioning their careers. If this continues, the quality of care would be jeopardised not because of the migrants but because of Japan's disparate migration schemes and lack of ethical recruitment principles based on the WHO Code.

6. Conclusion

This chapter elaborated on multiple frameworks of Japan's immigration policy for care workers. It also examined the consequences of deregulation in light of global migration governance. Whilst the EPA care workers have successfully brought positive impacts, the programme has turned out to be too costly for employees, and therefore the number of workers has not expanded enough to mitigate the labour shortage. The EPA programme has revealed the dilemma embedded in care work in Japan: educating migrants to become certified care workers is costly and time-consuming, whilst migrants may not necessarily stay.

Whilst the new channels allow more migrants to enter, they are dominated by market forces and raise the issue of ethical recruitment policy for health workers based on WHO. These labour migration channels for care workers can be disparate, fragmented, and lack transparency, making it difficult for the care sector to have a long-term strategy to ensure human resource development. Similarly, if migrants are not well informed when deciding to migrate, their entire educational and career prospects could be wasted.¹⁷

However, even though it has been mediated by private agencies, the market still operates under the regulatory framework of the state, which has the responsibility to ensure fair practices in the labour market. We need to rethink how to conceive migration policies with coherence and care work that ensures proper working conditions and career paths, as well as citizenship that enhances the capabilities of both Japanese and migrant workers.

¹⁷ This occurred for the early batch of EPA care workers because the applicants were not informed of what exactly it meant to work as a 'care worker'. There is no job equivalent in the sending country, and therefore no equivalent terminology exists. The misleading translation of 'care work' as 'nursing care' in the SSW by the Ministry of Foreign Affairs (n.d.) is repeating the same mistake once again, as the job of care workers in Japan is defined differently from nursing.

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Chapter 3

Cost of Hiring Foreign Care Workers for Employers: Implications of the EPA Policy

Kunio Tsubota

This chapter discusses the costs of Japan's policies to accept foreign care workers (FCWs), mainly from the viewpoint of employers, and attempts to draw some policy implications for the new gate-opening measures recently introduced. Discussions are made in reference to the estimated economic costs generated in a precedent policy of accepting FCWs under the economic partnership agreements (EPAs). Section 1 briefly reviews the changes in recent policies on receiving FCWs in Japan. Section 2 examines the employers' costs in the EPA based on the two questionnaire surveys collected by mail. Section 3 examines the possible changes in cost sharing under the new gate opening measures by recomposing the EPA cost estimates. Section 4 discusses the implications of the major findings, keeping in mind the economic viability of Japan's FCW policies.

1. Background

With few specific exceptions, Japan has mainly accepted only highly skilled professional foreign workers who engage in non-human service sectors, particularly until 2018. A notable exception was the acceptance of FCWs under the bilateral EPAs with three Asian countries (i.e. Indonesia, the Philippines, and Viet Nam) which started from FY2008. However, despite the rising demand for long-term care, the acceptance has been limited to 300 workers a year and subject to strict conditions. FCWs are required to have a nursing diploma or college degree with care experience, be recruited through a semi-governmental agency (Japan International Corporation of Welfare Services (JICWELS)), and be employed only by authorised care facilities. If they wish to continue working in Japan after completing the EPA programme, they have to pass the national exam to become a certified caregiver within 4 years after they start working in Japan. In return, for these strict entry conditions, the EPA FCWs are protected by the Labour Standards Act and guaranteed working conditions equal to Japanese care workers. Table 3.1 shows the basic features and conditions set for the EPA care workers.

Table 3.1. Basis Features of EPA Care Workers

Economic Partnership Agreement (EPA) Foreign Care Workers	
Legal base for acceptance	Bilateral EPA with sending countries
Starting year (sending country)	2008 (Indonesia), 2009 (Philippines), 2014 (Viet Nam)
Recruiting agency	Semi-governmental body (JICWELS) only
Qualification	4-year college degree plus care experience, or a 3-year nurse school certificate
Language training before arrival	6–12 months at a designated school in the sending country
Employer	Approved care institutions only
Labour contract	Formal, subject to standards set by laws
Training after arrival	6 months for language and others in designated boarding school, and 3–4 years for the national exam
Wages and other working conditions	Equivalent to Japanese care workers subject to the Labour Standards Act
Maximum length of stay	4 years (but no limit if passed exam)
Number of accepted FCWs	4,265 (total, FY2008–2018)

Source: Ministry of Health, Labour and Welfare (n.d.); JICWELS (n.d.).

The total number of accepted EPA care workers since its inception reached 4,265 in FY2018. Although the EPA FCWs programme was developed to facilitate bilateral economic activities and is not designed to ease the shortage of care workers (at least, officially), this is only a tiny fraction of the 260,000 care workers additionally required in Japan for 2020 (Ministry of Health, Labor and Welfare, 2017). Foreseeing further shortages of care workers, the government has started loosening the tight entry control of FCWs. In September 2017, a new residential category of ‘care’ (*kaigo*) became effective, so international students (IST) of caregiver schools can stay and work without limit once they have passed the national exam for certified caregivers (*kaigo-fukushi-shi*). In November, another path opened for FCWs to work as ‘trainees’ under the existing Technical Internship Training Program (TITP).

In December 2018, a more fundamental change in migration policy took place. For the first time in history, Japan opened the gate for non-professional workers for the reason of a ‘labour shortage’. The Immigration Law was amended to accept the entry of foreign workers who

have 'a certain level of skills' in 14 job areas, including care services (Ministry of Justice, 2018). This new residential category is called '*tokutei-ginou*' (specified skilled worker: SSW).

However, these new opening measures still have many strict conditions and controls to ensure the orderly acceptance of qualified FCWs. For instance, FCWs have to pass specific tests on Japanese language and care skills before or after entry or have sufficient caregiving experience in Japan, such as through the EPA programme. Employers must be qualified care facilities that follow government guidelines on the working and living conditions of FCWs, comply with labour related laws and, inter alia, ensure that FCWs' wages are equal to those of Japanese care workers. These conditions are essentially similar to those applied to EPA FCWs and employers.

It is no doubt that the new opening measures can bring benefits for selected FCWs and to the Japanese elderly, even though considerable conditions remain. Japanese wage levels were still eight times higher than those of Indonesia, the Philippines, and Viet Nam in 2018. The difference in demographic structure also lures FCWs to Japan. The ratio of the population aged 15–24 to those aged over 65 in 2015 was 3:1 in the three countries, whereas it was 1:3 in Japan (United Nations Population Division, 2019). Care institutes in Japan who are confronting worsening shortages of labour badly need young care workers.

However, when we turn our eyes to the situation of employers and the government, different pictures emerge. A study suggests that the annual economic cost for employers and the government to accept a FCW in the EPA programme is as high as US\$7,600¹⁸ and US\$18,700, respectively (Tsubota, 2018). The main reason for this high cost was that the EPA gate opening was introduced neither as an immigration policy nor a labour policy but as a by-product of trade agreements. For this reason, almost all the costs of accepting and fitting FCWs to the Japanese care system were borne mostly by the government and employers.

In the new gate opening measures, the cost burden of the government will be partly reduced or passed on to employers and FCWs. However, employers' cost burden may remain unchanged or become even higher. Their financial capacity that hinges on the reimbursement from the Long-term Care Insurance (LTCI) is quickly eroding as the ageing population and stagnant economy continues. If the burdens on employers and/or the government are excessive, not many FCWs will be hired even if the gates open further.

2. Estimated costs for employers to hire EPA care workers

Various costs inevitably accrue from the acceptance of FCWs. Costs of agency services, travel, documentation, language and skill training, lodging and salaries, and management and monitoring are amongst them. These costs are shared by major stakeholders, i.e., FCWs, employers, and the government. How have they been shared by the employers in the EPA?

Two surveys are available in this regard. One was conducted by mail in February 2012 and the other was similarly done in April 2019. Both surveys targeted the same 264 care facilities that

¹⁸ Excludes salaries and bonus.

accepted EPA FCWs during FY2008–2011. The 2019 survey is a simplified follow-up survey of the previous one. The collection rates were 32.6% and 18.2%, respectively. Although the question content, covering periods,¹⁹ and respondents were not necessarily identical, the surveys allow us to make some blunt comparisons.

Table 3.2 summarizes the estimates of the average ‘additional cost’²⁰ required for the care facilities to hire an EPA FCW during the 4-year contract period. It was about ¥2.2 million excluding salaries, allowances, and bonus in 2018. This amount has not changed very much since 2012, though its composition and share have changed.

Care facilities had to pay ¥800,000 to receiving an FCW in their workplace according to the 2019 survey, whilst the amount was about ¥900,000 in the 2012 survey. This is a sort of fixed cost accruing only once during the contract period. It comprises two elements, i.e. payments to agencies and travel costs. Agency costs include the costs of recruitment and matching conducted by JICWELS, an initial obligatory training course upon arrival, daily subsistence for FCWs, and surcharges paid to the sending country.

The training and education costs include the ones that care facilities actually paid tutors/teaching materials to assist FCWs in Japanese language and preparation for the national exam. They cost about ¥400,000 per FCW in both surveys. The item ‘specific allowances’ can be a controversial one in terms of the validity of categorising it as the cost to employ EPA-FCWs because they may be paid to Japanese staff as well. However, it was included in the ‘additional costs’ as our interviews often suggested that the care facilities offered ‘special’ subsidies for lodging, food, and powers that are not applicable for Japanese staff. This amount is reached ¥2 million per FCW in 2019. This means that ‘providing an appropriate living condition’ for foreign workers requires substantial costs.

Table 2.2. Estimated 4-Year Additional Costs for Employers in the EPA
(¥1,000 per FCW)

	2019	2012	Components
Agency costs	523	750	Payments to 1) JICWELS, including the cost for recruiting, matching, and coordination, and 2) the training agencies to cover the costs for the 6-month training after arrival
Travel costs	277	148	Airfare of the FCWs, travel costs of the employer's staff for matching and receiving FCWs, etc.

¹⁹ FY2008–2011 (2012 survey) and FY2008–2018 (2019 survey). The former was a trial period for most care facilities and, thus, the derived cost estimates may include a sort of initial investment cost.

²⁰ ‘Additional cost’ means the extra expense and additional staff time required for receiving and assisting FCWs. If the same lodging allowance is paid to Japanese staff as well, or staff assist FCWs within their normal routine work, the expense and staff hours are not counted as additional costs.

Training and education costs	397	398	Costs paid by employers for language and skill training and support for the national exam
Allowances	982	664	Specific allowances for lodging, food, and others
Sub-total	2,179	1,960	
Government subsidies	-159	-173	Subsidies for hiring FCWs, language training and exam preparation
Staff additional labour (opportunity cost)	680	1,306	Staff labour hours additionally required for training and taking care of FCWs
Total	2,700	3,093	
(ref.) No. of care facilities responded	48	86	

Source: Original data of the author.

Table 3.2 has two more cost items, government subsidies (negative costs) and additional staff labour. Care facilities receive subsidies from the central/local governments to assist FCWs. The subsidy amount varies by the location of the care facilities. Some facilities reported receiving ¥1 million per FCW, but many others reported smaller or no subsidies. The average was about ¥165,000 per FCW.

The additional staff labour required is a hidden cost element and a major source of stress for the care facility staff. The 2019 survey shows that in a normal month of 2018, about 40 staff hours were allocated to taking care of EPA FCWs. Of this, on average 14.1 hours and 14.5 hours were used for Japanese language training and assisting with preparation for the national exam, respectively. The staff needs to teach or assist the FCWs, who has limited Japanese language abilities. Documentation and support for FCWs' daily lives also required individually on average 5.5 hours and 4.9 hours. We have to keep in mind that these were additional workloads for facility staff and not the kind of tasks to be done by ordinary staff. These labour hours were converted to monetary values as 'opportunity costs' by using the rate of ¥1,595/hour, which is the average wage for care facility staff reported in the government wage survey (2019). The estimated staff labour cost per FCW was ¥680,000 in the 2019 survey, which was ¥620,000 less than in the 2012 survey. The reduced staff labour hours per FCW are attributable to 1) the increased number of FCWs per care facilities, 2) accumulated institutional knowledge on FCWs in the care facilities, and 3) the lengthened period of Japanese language training before entry.²¹

²¹ In the early stages of the EPA, language training before arrival used to be 3–6 months, but now it is 6–12 months depending on the sending country.

Combined, the 4-year cost for care facilities is estimated at ¥2.7 million per FCW, down by ¥300,000. This decline in the staff labour cost is a good sign, but the level of economic burden remains high. We have to keep in mind that the care facilities paid, on top of this cost, more than ¥10 million per FCW for 4-years as salaries under the condition of having equivalent salaries to Japanese workers.

This situation is well reflected in the answers of the respondents to the questions on the economic viability of FCWs (Table 3.3). Only 4% of respondents said FCWs were economically viable under the current conditions. Even if other indirect benefits, such as the positive impact on Japanese staff or having an international image, are counted, the economic viability was admitted by only 23% respondents. The answer item chosen by most respondents was 'economically viable if FCWs continue to work in the same facility after passing the national exam' (54%). In other words, they felt that if an FCW who had passed the exam change their employer or returned to their home country soon, the economic benefits would disappear. Indeed, 13% respondents explicitly replied so.

Table 3.3. Perceived Economic Viability of FCWs: Employers
(%)

	2019	2012
Viable under current conditions	4	0
Viable as other benefits also accrue	19	17
Viable if FCWs are counted in the payment from the LTCI	-	26
Investments for the future	10	33
Viable if FCWs continue to work after passing the national exam	54	15
Not viable because of the difficult national exam	0	-
Not viable because of frequent resignations or changes in employers after passing the national exam	13	-
Not viable by any means	0	8
Total	100	100

Source: Original data of the author.

This concern is critical for them. In the 2019 survey, more than 70 % of facilities replied that a considerable number of EPA FCWs had returned to their home countries before the 4-year contract had expired, or that they had changed their employers or returned to their home countries after having passed the national exam (Table 3.4).

Table 3.4. Number of Facilities with FCWs Who Returned to Their Home Countries or Changed Employers

	Returned to home countries before contract expired		Changed employers or returned to home countries after passing the national exam	
	No. of facilities	%	No. of facilities	%
None did	16	35.6	13	28.9
Few did	24	53.3	22	48.9
Many did	5	11.1	10	22.2
Total	45	100.0	45	100.0

Source: Original data of the author.

3. Possible costs for key stakeholders under the new entry measures

The new opening measures sound like good news for most care facilities. Unlike the EPA FCWs, no official ceilings on the number of acceptable FCWs exist.²² No nursing certificate/college degree is required for FCWs regardless of its type. Care facilities are relieved of the pressure of helping FCWs pass the national exam. In the TITP and SSW, FCWs can stay a maximum of 5 years, and, in both programmes, they can stay further after passing the national exam. FCWs who started their career in Japan as international students are supposed to pay all the costs by themselves.

However, will the employers' economic viability of hiring FCWs improve with these new measures? It may be premature to discuss this because no data on the new measures are currently available. However, we may get a rough idea through an 'exercise on paper' by reviewing and 'recomposing' the cost components of the EPA in accordance with the policies specified in each new measure.

3.1. Basic assumptions of the cost estimate exercise

A starting assumption is that whichever entry routes are used, someone must pay similar costs to enable FCWs to work as qualified caregivers and live in harmony with other people in Japan. The benchmark to be used is the costs for EPA stakeholders estimated in US dollars based on the 2012 survey. In the EPA, these costs have been shared exclusively by the government and employers, but in the new measures, some of the government costs may be reduced or passed on to employers and FCWs. Some costs that employers pay in the EPA would be shared by FCWs. To make the comparison easier, the costs are estimated for 4 years (the FCW contract period in the EPA) for all measures, although the actual time required may

²² However, the government announced a 'forecast' on the number of SSWs in each area. For the care services it was 60,000 in the coming 5 years.

vary by the measure.²³ The EPA 2012 cost data are converted in accordance with the US dollar–yen rate in 2018.

Other major assumptions made for each new measure are as follows.

(1) TITP

- Language/skill training costs: 6 months of training supported by the Japanese government before arrival is not required any more, but either FCWs themselves or employers have to pay the training cost for FCWs' Japanese language skills to reach the JLPT N4 level. The 6-month training after arrival is not required any more, but employers have to pay the cost of 1–2 months of introductory training after arrival (obligatory).
- Agency costs: employers have to pay the costs of recruitment, matching, documentation, the FCW's travel, and other administration fees to the authorised private agency instead of a payment to JICWELS. Employers also have to pay the agency every month a supporting fee to verify the appropriate implementation of the approved training plan. The supervision agency for the TITP is the Organization for Technical Internship Training (OTIT). We conducted this cost estimate exercise assuming the cost size is the same as the EPA programme.

(2) IST

- Recruitment and language/skill training costs: FCWs come to Japan as an international student and learn Japanese language in a language school for a year. After completion, they learn care skills and related knowledge in a caregiver school in Japan for 2 years. The costs include those for migration as an international student, agency, admission and tuition for schools and for living in Japan during the schooling period. After receiving them as certified caregivers, employers have to pay half of the cost of the on-the-job training for EPA FCWs.²⁴
- Subsidies: International students receive scholarships or concessional student loans. The government compensates one-third of the employer's scholarship to FCWs who study in caregiving schools.²⁵ International students are also eligible for concessional student loans from local governments through caregiver schools. Loan repayments are exempt if FCWs work as certified caregivers in the same local area for 5 years. In our cost estimation, we assume that FCWs would choose the scholarship through their employers.

²³ The base contract period is 3 years, but this is extendable by 2 years in the TITP. International students need at least 3 years for schooling. The SSW contract is 1 year but extendable up to 5 years.

²⁴ Graduate students from a caregiving school used to be automatically granted the title of 'certified caregiver', but it is likely that international students need additional training to reach the level of graduates of the EPA programme. In 2017 this rule was modified so that students of caregiver schools have to pass the national exam to get the title. The application of this new rule was suspended by another 5 years (this is the third suspension) and will begin to take effect only for graduates in 2022. We assume that half of the employer's on-the-job training costs would be required further.

²⁵ One-third of the 'base' costs that are fixed by each item (i.e. tuition, admission fee, job application cost, national exam preparation and living cost) are subsidised for care facilities who provide scholarships to students (MHLW, Tokyo Municipal Government). As the actual costs are often much higher than the base costs, it is assumed that employers pay two-thirds of base costs and FCWs pay the difference between the estimated actual costs and the base costs.

- Food/lodging subsidies and agency fees for supervision: These are not required because once FCWs pass the national exam, they are neither 'candidates'²⁶ nor 'students' who require special support.

(3) SSW

- Language/skill training costs: FCWs who have acquired this category of state of residence are supposed to have 'certain levels' of Japanese language capacity and care skills so that they can start working immediately after entry. Applicants are those who have passed the specific tests or completed the EPA or TITP programmes. This means that most of the training costs are paid by the FCWs themselves or those who have been involved in the previous programmes. Employers' costs for training are nil if the FCWs have completed the EPA or TITP programmes.²⁷ We assume that FCWs pay the same amount of cost as international students have to pay for training net of government subsidies.
- Recruitment costs: Employers have to pay the costs of recruitment, including those for matching and documentation. Travel costs are assumed to be paid by employers.
- Costs of 'employer's duty': Employers are obliged to extend their 'support' to FCWs in many aspects²⁸ in addition to the ordinary duties arising from labour contracts and the related laws (Tsubota et al., 2015). Employers may do it by themselves, but we assume they would ask the registered supporting agency (RSA) to take up these duties on commission. The agency fee rate is determined by market forces but is likely to be higher than the rate of TITP agents due to the heavier workload.
- The government needs to bear the cost for monitoring and supervision, as in the EPA and TITP.

The assumptions and cost data are summarised in Table 3.5. Possible cost data are derived from the EPA study (Tsubota, 2018; Tsubota et al., 2015) and the websites of the relevant agencies (One World Japanese Language Centre, n.d.; Gaikokujin Roudousha Shinbun, n.d., Tokyo Global Connect, n.d.; Tokyo Metropolitan Government, n.d.).

²⁶ In the EPA, FCWs are called 'candidates' to be a qualified caregiver until they pass the national exam.

²⁷ However, some concerns remain for the FCWs who have passed the exams for the SSW outside Japan. Except for those FCWs who have returned to the sending countries after the experience of the EPA or TITP programmes, more practice in Japanese language and actual care skills would be required to reach the level of the skills of final year EPA FCWs.

²⁸ For instance, providing a detailed prior 'guidance' on contracts, laws, and working and living conditions in a language that FCWs can understand, making a concrete 'support plan', finding appropriate lodging, giving Japanese language lessons, counselling by experts, arranging interpreters when asked, reporting every 3 months the status of the FCW, their conditions, and progress of the support plan, assisting in finding new employers if unable to continue to employ, and so on.

Table 3.5. Costs to Be Paid by the Three Stakeholders Under Four Different Entry Measures

Cost Component		Entry Measures				Possible Cost (¥1,000/FCW)	
		EPA	TITP	IST	SSW	Value	Source
1	Agent fee for migration	EM	EM	EM	EM	410	EPA study
2	Training before arrival (6 months)	JG				1,819	EPA study
3	Language training before arrival		EM	EM		200	One World Japanese Language Centre
4	Training after arrival (6 months)	JG				3,557	EPA study
5	Training after arrival (obligatory 1–2 months)		EM			156	Gaikokujin Roudousha Newspaper
6	Schooling and living costs (3 years)			CW		2,559	Tokyo Global Connect
7	Subsidies for schooling		JG	JG		1,107	Tokyo Metropolitan Government
8	Scholarship by employers			EM		2,214	Assume the same as above
9	Visa renewal	EM		EM		20	EPA study
10	Training expense of employers	EM	EM	EM		546	EPA study
11	Additional staff labour costs	EM	EM	EM		1,791	EPA study
12	JICWELS administration fee	EM				110	JICWELS
13	Agent fee for supporting		EM		EM	2,953	Gaikokujin Roudousha Newspaper
14	Food/lodging allowances	EM	EM			869	EPA study
15	Training and exam subsidies	JG	JG			1,760	EPA study

16	Supervision	JG	JG		JG	1,059	EPA study
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CW = foreign care workers, EM = employers (care facilities), JG = Japanese government.

Notes: Costs from the 2012 EPA study were converted to 2018 prices (US\$1 = ¥78.9 to ¥109.4).

Cost figures in *italic* are estimates. Data were derived through websites accessed in August 2019.

Four months training before arrival is assumed for the FCW to reach JLPT N4.

Visa renewal costs for the TITP and SSK are included in the agent fee.

Source: Original data of the author.

3.2. Estimated possible costs and cost sharing amongst stakeholders

Table 3.6 shows a rough magnitude of the estimated possible costs that would be shared by the three key stakeholders under four different entry measures. We can point out several notable findings.

First, the government per FCW cost burden would fall sharply in all three new measures from ¥8 million in the EPA to ¥1–¥2 million. The main reason is the exemption of the government from the duty of two 6-month training periods before and after arrival, which require ¥5.4 million per FCW in the EPA case.

Second, the employer's cost burden would increase rather than decrease in all new measures. The increase is particularly large for the TITP measures. Employers have to take on some of the costs of language training that the government used to pay. And more importantly, employers in the TITP and SSW have to pay around ¥40,000–¥50,000 per month per FCW to the agencies who carry out monitoring and advisory tasks instead of the employers and the government. Therefore, employers' costs would not decline, even in the case of SSWs where no particular training costs are required.

Third, the decline in employers' costs would be marginal in the IST even if we assume that the government provides scholarships and that FCWs themselves pay part of the schooling costs. The main reason is that very high schooling and living costs (¥6 million per FCW for 3 years) require additional support from the potential employers.

Fourth, in all new programmes, the total cost per FCW would not decline very much compare to the EPA. Government costs would fall sharply from ¥8 million to ¥1 million–¥2 million but would be partly offset by the increased costs of employers and/or FCWs for training and agency services.

Fifth, the share of training costs in the total cost to employ FCWs is high in the EPA (65%) and IST (58%). The relatively modest share in the TITP (40%) is a reflection of the shorter training time (4 months in the sending country and 1–2 months after arrival) compared with that of the EPA (6 months in the sending country and 6 months of training in a boarding school after arrival).

Table 3.6. Estimated Costs for Key Stakeholders by Entry Measure

(¥ million/FCW)

Stakeholder	EPA	TITP	IST	SSW
Foreign care worker	0.0	0.2	2.8	2.8*
Employer (= care facility)	3.7	6.7	4.1	4.2
Central and local governments	8.2	2.0	1.1	1.1
Total	11.9	9.0	8.0	8.1*
(of which education/training cost)	7.7	3.6	4.6	2.8 *

Note: Cost figures in italic are estimates.

Source: Original data of the author.

3.3. Policy implications and the future of Japan's long-term care system

In 2008, Japan agreed for the first time to accept a small number of foreign care workers under the EPA. The government said that this was not due to the shortage of care workers. However, the situation of the Japanese care system has drastically changed since then. Rapid ageing population has accelerated the shortage of care workers. It is now forecast that the size of the shortage may reach 550,000 workers by 2025 (MHLW 2017). Against this background, the government introduced several gate opening measures for FCWs in the last 2 years, i.e. creating a new residential status for caregivers, acceptance to the technical internship programme, and allowing the migration of FCWs who have a certain level of skills. These new measures sound like good news for employers who are confronted with severe labour shortages.

However, our exercise on paper indicates that employers' cost burden would increase rather than decrease in the new measures. The past two surveys suggest that accepting EPA FCWs is economically sensible only if FCWs continue to work in the same facility. With further increases in possible costs, would many care facilities wish to hire more FCWs under the new measures? We can consider two possibilities.

One is the case that the current policy framework, including budgetary support, continues. The number of hired FCWs will increase but mainly in large and financially sound private care facilities. They can afford and attract FCWs through EPA and TITP programmes whilst investing in international students. They would start hiring the 'graduates' of these programmes as SSW FCWs. However, small and financially weak care facilities would not be able to hire FCWs who are costly and risky for them.²⁹ As a result, the number of elderly in the waiting lists of care facilities will remain or even increase.

The other case is the possibility that worsening labour shortages will compel the government to ease the entry control further and turn a blind eye to the quality of care services and an

²⁹ FCWs can change employers once they pass the national exam. This becomes a big risk, especially for small and financially weak care institutions.

increase in social costs. The recent successive gate opening measures suggest that this is also a likely scenario. The government may increase the number of acceptable FCWs, lower the hurdle on language and skills,³⁰ simplify the national tests and monitoring/inspection, and make labour standards more flexible, and so on.

Whichever possibility comes true, population ageing will further advance and aggravate the shortages of care workers in Japan. Budget deficits are swelling every year under the stagnant economy, and so are the costs of social security systems, including the long-term care insurance. If an increase in budgetary support and a raise in the insurance premium is difficult, not many options remain. Although relying on the FCWs could be a possible option, it has many shortcomings and side effects too. This study indicates that FCWs are not necessarily low-cost labour, even now. Somebody has to pay the costs of recruitment, migration, supervision, and, inter alia, education and training. It would be the employers who pay the cost when financial assistance from the government ebbs away. How long can Japan's long-term care system be sustained?

One silver lining is that FCWs who have been hired under these measures may help disseminate Japanese care skills and knowledge after their return to home countries. With relatively high standards being required, the current FCW policy framework looks costly for Japanese employers and the government but may contribute to the dissemination of quality care services in these countries where population ageing will come sooner or later. From a longer and global perspective, these costs might be partly regarded as an investment for the better welfare of these countries.

³⁰ Indeed, the level of Japanese language proficiency required for TITP applicants was lowered from N3 to N4 in the process of consultation with concerned parties. In the same vein, verification of a 'certain level of skills' by tests was exempt if SSW applicants had completed the EPA or TITP programmes or caregiver school. The government plan to make the passing of the national exam obligatory for caregiver students was postponed three times since 2014.

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Chapter 4

Return Migration of Vietnamese Nursing Graduates: Trajectories of the First Batch of EPA Care Workers in Japan

Yoichi Hiruma, Yukari Amano, and Yuko O. Hirano

1. Introduction

Between 2014 and 2019, Viet Nam sent six batches of 966 nurse graduates to Japan under the Japan-Viet Nam Economic Partnership Agreement (JVEPA). This bilateral agreement offered Vietnamese nurse graduates the opportunity to enter a scheme wherein they could act as care workers in Japanese care facilities whilst studying to become national certified care workers in Japan.

After being selected for the JVEPA scheme, successful applicants underwent a year of group training, including about 1,500 hours of Japanese language learning and about 300 hours of sociocultural adaptation, in Viet Nam. Only nurses who had passed the Level 3 Japanese-Language Proficiency Test (JLPT) and demonstrated an understanding of conversational Japanese were able to migrate to Japan. Following placements lasting around 3 years and 6 months, in which candidates studied whilst working in care facilities, nurses who passed the national exam became certified care workers in Japan.

It is difficult for foreigners to pass the national exam in Japanese, and the pass rate of candidates from the Philippines and Indonesia was approximately 40% in the examination conducted in January 2018. While, Japanese passers of the national exam is 73.7%.³¹ However, the first batch of Vietnamese candidates had a pass rate of 93.7%, which was higher than the Japanese candidates' pass rate. Despite this, after becoming certified care workers, many Vietnamese nurses did not renew their residence status as Economic Partnership Agreement (EPA) care workers in Japan. Many returned to Viet Nam or applied for another residence status in Japan.

Previous studies on EPA care workers from Indonesia and the Philippines revealed that the primary reason for repatriation was their inability to pass the national examination. Studies have also suggested that this is a reflection of their dissatisfaction with care work in Japan (Kurniati et al., 2017; Vilog et al., 2020). However, it has been frequently reported that experience in Japanese care work does not increase candidates' employment opportunities in their home countries (Asai and Miyamoto, 2017). Therefore, this study proposes the following research questions:

³¹ See the Japanese Ministry of Health, Labor and Welfare (MHLW) website.
<https://www.mhlw.go.jp/content/12004000/000493552.pdf> (accessed 27 May 2020).

- (1) Why did Vietnamese care workers leave their occupations as certified care workers in Japan, despite having overcome various challenges and having passed the national exam?
- (2) Are Vietnamese care workers' experiences in Japan useful in terms of career options in Viet Nam?

2. Methods and participants

(1) Researchers

Hiruma specialises in the cultural anthropology of Viet Nam, Hirano in sociology of health and illness, and Amano in nursing and care welfare.

2.1. Data survey

According to data provided by the Japanese Ministry of Health, Labour and Welfare,³² the trajectory of the first batch of Vietnamese candidates (from their selection to the present) is roughly as follows. The first batch was notified of the open recruitment in August 2012, and 124 applicants were selected in October 2012. Following the selection, these applicants underwent a year of group training in Viet Nam. This resulted in a total of 117 applicants, 115 who passed level N3 of the JLPT and 2 who had already obtained N2 of the JLPT (and thus were exempt from a year of group training) arrived in Japan in June 2014.

After arriving in Japan, these candidates underwent further group training consisting of 140 hours for Japanese language training and 140 hours for sociocultural adaptation; the main basis of the sociocultural training in Japan being practice in care work. Following 2 months of training, in August 2014, they began working in facilities across Japan. In the period leading up to the January 2018 national exam, 22 candidates (18.8% of the total) relinquished their EPA care worker status prior to the exam. The majority of them returned to Viet Nam, whilst some remained in Japan with a different residence status.

Vietnamese candidates had a pass rate of 93.7% in the national exam; 89 of the 95 candidates became certified care workers in Japan. Of the six candidates who failed the exam, four returned to Viet Nam, whilst the remaining two staying in Japan to re-take the exam in January 2019. Candidates who passed the national exam were able to continue working in Japan by renewing their residence status once every 3 years. If they returned to Viet Nam, they could re-enter Japan as an EPA care worker if they found employment in a care facility.

However, 24 of the certified care workers left their occupations by January 2019, within the year following the national exam. The majority of them returned to Viet Nam, whilst some remained in Japan with a different residence status. By January 2020, within 2 years of the national exam, 12 more certified care workers had left their occupations. Therefore, in the 5 years and 6 months following their arrival in Japan in 2014, 53 individuals (45.2% of the 117 candidates) remained in Japan and continued to work as EPA certified care workers, whilst 64

³² Based on the author's interview with an official from the MHLW in 2020.

individuals (54.8% of the total) left their occupations in Japan.

2.2. Questionnaire survey (quantitative survey)

Participants in this survey were the first batch of JVEPA care worker returnees (ex-EPA care workers).

The data were collected through an anonymous questionnaire (in Vietnamese), which was distributed online through the JVEPA's Facebook group. In addition, a snowball sampling method was employed. Data pertaining to demographic characteristics and candidates' current situations following their return from Japan were collected. Data pertaining to their reasons for returning to Viet Nam and their job satisfaction were measured using a four-point Likert scale. This was a joint survey distributed between February and December 2019.

The data of 17 participants who provided valid answers were analysed by Hiruma and Hirano.

2.3. Semi-structured individual interviews (qualitative survey)

A semi-structured interview (in Japanese) was conducted, with 11 participants (1 male and 10 female). This sample was obtained through a snowball sampling approach applied to the 17 respondents who provided valid answers in the quantitative survey.

After obtaining informed consent from the participants, who were aware of the content, method, and ethical considerations of the interview, the survey was conducted by the researchers (Hiruma and Amano) in a private room. The interviews were digitally recorded and then transcribed.

The transcriptions were thoroughly examined to obtain a clear overview. Multiple qualitative analyses were conducted pertaining to the participants' reasons for returning to Viet Nam, their career choices after returning, their perceptions of their experiences in care work in Japan, and their current occupations. To avoid any discrepancies resulting from the interpretation of the Japanese interview, one of the researchers (Hiruma) conducted interviews in Vietnamese with two participants and confirmed that there was no discrepancy.

Notably, three of the 11 participants became key informants (hereinafter, referred to as Ms. A, Ms. B, and Ms. C) for the researchers (Hiruma and Amano). The researchers conducted multiple in-depth interviews with these three informants in Japan and Viet Nam for over 5 years, beginning in 2014 (Hiruma and Amano, 2018; 2019). When interpreting the survey data, we utilised the deeper understanding gained from these continuous interactions with key informants.

This study was approved by the ethics committee of Nagasaki University, and informed consent was given by all prospective participants prior to entering the study.

3. Results

3.1. Quantitative findings

The sample group of 17 respondents comprised 13 females (76.4%) and 4 males (23.5%), with an age range of 27–32 years and an average age of 28.2 years.³³ Over half of the participants were married (58%). The number of years spent in nursing education was either 3 (76.4%) or 4 (23.5%) years. All respondents (100%) had JLPT N2 or higher in terms of Japanese language proficiency.

Table 4.1. Reasons for Returning to Viet Nam (multiple choice answers)

Reason for returning to Viet Nam	4 (agree)	3	2	1 (disagree)
Because I was not satisfied with my work in Japan	0	11.7	29.4	58.8
Because I could save money after I worked for a certain number of years in Japan	0	17.6	41.1	41.1
Because I wish to care for my family in Viet Nam	52.9	29.4	11.7	5.8
Because I want to spend my married life in Viet Nam	23.5	47	17.6	11.7
Because I wish to develop my career in Viet Nam	11.7	52.9	23.5	11.7
Because I felt tired after work when I was in Japan	5.8	23.5	29.4	41.1

Source: Original data of the author.

As shown in Table 4.1, many respondents indicated that their reasons for returning to Viet Nam were ‘Because I wish to care for my family in Viet Nam’ (82.3%) and ‘Because I want to spend my married life in Viet Nam’ (70.5%). Additionally, many respondents did not indicate that it was ‘Because I was not satisfied with my work in Japan’ or ‘Because I felt tired after work when I was in Japan’, with 88.2% and 70.5% disagreeing with these statements, respectively.

Regarding their current situation after returning to Viet Nam, the majority of the participants worked full-time (88.2%), and the frequency with which Japanese was used in their current occupations was ‘7 days a week’ (75%) and ‘2–3 days a week’ (25%). The purpose of using

³³ All respondents were already above the average age of first marriage for females (23.1 as of 2017). See the General Statistics Office of Vietnam website: https://www.gso.gov.vn/default_en.aspx?tabid=774 (accessed 27 May 2020).

Japanese in their workplaces was found to be in a teaching capacity (50%) and in interpretation and translation (31.2%).

Table 4.2. To What Extent Were You Satisfied with Your Working Conditions in the Following Situations in Japan? (multiple choice answers)

Job satisfaction	4 (satisfied)	3	2	1 (dissatisfied)
Salary and compensation	23.5	58.8	17.6	0
Relationship with Japanese colleagues	35.2	47	17.6	0
Relationship with Japanese employers (N=16)	18.7	43.7	31.2	6.2
Degree of autonomy as a health professional	23.5	52.9	23.5	0
Degree of pride in your work as a health professional	47.0	47.0	0	5.8
Strictness of work management at your workplace (N=16)	25.0	62.5	12.5	0
Content of your work	29.4	52.9	11.7	5.8
Working condition (N=16)	12.5	81.2	6.2	0
Overall, how satisfied were you with your work life in Japan?	23.5	70.5	5.8	0

Source: Original data of the author.

Table 4.2 illustrates that job satisfaction was high overall, but satisfaction in terms of their 'relationship with Japanese employers' (37.4%) was low. When asked whether they would like to go to Japan again if they had the chance, 10 of the 13 participants responded positively.

3.2. Qualitative findings

Following a qualitative analysis of the interviews, we chose to call the reasons for returning to Viet Nam 'pull factors' when there was a strong influence seen from the Vietnamese side and 'push factors' when there was strong influence seen from the Japanese side.

(1) Pull factors

The most common reasons for returning to Viet Nam were marriage, childbirth, and family care. Many participants wanted to meet their Vietnamese family's expectations, despite their personal willingness to continue working and living in Japan. After completing a nursing

course lasting 3–4 years, it takes 5–5.5 years from application to the EPA programme to passing the national exam. Many Vietnamese women are expected to marry, have children, and care for them.

Informant 1 revealed, 'My family was worried about me being unmarried. They want me to be stable here. I still wanted to stay in Japan, but I decided to leave because of my family.' Informant 2 said, 'I returned to my home country to marry a man who I had been dating since college. He was waiting for me.' A third informant said: 'My child is small and often sick. I returned because of the child. [...] My mom was sick, too. My mother can't take care (of my child).' Many participants claimed they were expected to take care of their families. 'I returned to Viet Nam because my father was sick and no one was able to look after him', claimed Informant 4. Informant 5 said, 'Originally, I wanted to get married and continue living in Japan, but suddenly my boyfriend (an ex-EPA care worker) returned to Viet Nam because of his family (to care for them) [...] so I also returned to Viet Nam.'

Another pull factor that influenced the women's decisions to return was the kind of occupation they would find after returning to their home country. All 11 participants were engaged in the education and support (as interpreters, etc.) of young people who were willing to work in care facilities in Japan. Informant 6 revealed, 'If I didn't have this job, I would probably still be in Japan. [...] I want to work for this company most because I can use my knowledge of care work (obtained in Japan). Also, the treatment (salaries and benefits) is good.' Informant 3 claimed, 'This is a rewarding job. Since my childhood, my dream was to be teacher or a nurse; either was fine.'

(2) Push factors

There were also some factors on the Japanese side that encouraged participants to return to their home country. These were concerning their treatment and human relations in their workplace. Candidates' treatment under the EPA is based on their individual contract with their respective employment facility. Therefore, participants' salaries, holidays, the frequency and content of training, their living environments, etc. were not uniform.

One example of a 'push factor' caused by this in Japan was provided by Informant 7, who claimed her relationship with her teacher when studying for the national exam was unsatisfactory and tested her patience: 'Some 2nd and 3rd batch colleagues also returned to Viet Nam because they couldn't work with this person. I cried a lot and told the manager, but that upper (administrator) did not listen. I couldn't think of transferring to another facility because I had been there for 3–4 years (in that facility). So, I returned to Viet Nam.'

4. Discussions

4.1. Participant characteristics

The results described above seem to be related to two characteristics shared by participants in this study.

First, the characteristics of the participants in this study differ from those of previous studies in that all participants in this study passed the national exam. For example, the Indonesian returnees who participated in a study by Kurniati et al. (2017) had about a year of work experience in Japan and only 2 of the 15 participants passed the national exam. The participants of most of the previous studies were candidates who had not yet taken or could not pass the national exam, and these candidates voiced more dissatisfaction with care work in Japan, such as indicating that they were tired of care work in Japan (Vilog et al., 2020). Indeed, in the focus group discussion that we conducted with the first batch of Vietnamese care worker candidates in their second year in Japan (prior to taking the national exam), they expressed many negative opinions regarding care work in Japan, such as that they found it stressful to balance work and learning and that their nursing knowledge and experience was not utilised in their work in Japan (Hiruma and Amano, 2018). These facts led us to hypothesise that those who have passed the national exam have a more positive opinion of care work in Japan than those who have not yet taken the national exam or those who have not passed it. This is compatible with the results of a quantitative survey of returnee nurses and care workers (Hirano, Yoneno, Hiruma and Nugraha, 2021).

Second, almost all the participants in this study were women. We conducted interviews in a preliminary survey with two men, one of whom participated in this study, whilst the other was living in Japan with a non-EPA residence status. These two men were satisfied with their care work in Japan; however, they choose occupations that provided higher incomes and a better social status, rather than continuing to work as certified care workers.

The women's positive opinions of care work were based on their perception of the advanced knowledge and skills learned in Japanese care work and of its rewards. In addition, many expressed that they viewed it as stable work that was not overly challenging. For example, Informant 3 expressed, 'I thought the care work is good after passing (the national exam). [...] My salary goes up, and I have more guiding work. [...] If I am the one guiding, I don't have to do much (care work itself).'

4.2. Factors affecting the decision to return to Viet Nam

The reasons behind the candidates' return to Viet Nam are contextualised as follows.

The most important reasons were 'marriage and childbirth (child-rearing), family care and financial stability, expectations from their families and cultures that defined gender roles'. Amongst Vietnamese nurses, dissatisfaction with care work in Japan was not the main reason for returning to Viet Nam. Female participants wanted to meet the needs of their families and culture and prioritised marriage and childbirth (child rearing) due to their age.

These reasons for returning to their home country, such as marriage and family, have been identified by previous studies, such as in Indonesia (Efendi et al., 2013; King, 2020). However, we suggest that there is a context that is particular to the participants of this study.

In Viet Nam, there is a proverb which goes '*con gái mà gả chồng gần, có bát canh cần cũng đem cho*'. This translates to 'a daughter who marries near her parents brings even a vegetable soup.' As this proverb indicates, Vietnamese women are expected to live near their parents after marriage (Kato, 2019). However, it was not uncommon for participants to state, 'I want to return to Japan', even if they would not do so due to family expectations. Furthermore, one participant returned to Japan after this research period; therefore, it is necessary to conduct a follow-up study to observe the future trends.

Additionally, it is important to note that the participants were nursing graduates. One of the implications of this is that they were expected to play the role of a carer in their family. For example, Ms. B stated, 'The reason I decided to become a nurse was because my brother recommended that we have one nurse in the family because our mother had a chronic disease.'

This characteristic, of the candidates being nursing graduates, influenced their decision to return and find an occupation in Viet Nam. This is because they have a professional network of nurses, akin to the EPA candidates' Facebook group, in Viet Nam. For example, Ms. A, who did not return to Japan immediately after passing the exam, said, 'I have no experience working in Viet Nam, so I am not confident in educating or working with Vietnamese people.' After that, Ms. C, who had returned to Viet Nam earlier, invited Ms. A to work for the same company as her. Almost all participants in our interviews found their occupations through this professional network. Using this network helps them to share methods for properly utilising their knowledge, skills, and experiences and helps to alleviate anxiety after returning to Viet Nam. According to a study on Indian nurses in the United States, working-class migrant women tend to depend on family, kin, and local networks, but professional nurses use professional nursing networks from India, and these networks provide them with more opportunities (George, 2005). The results of the study are likely to be applicable to the ways in which the Vietnamese women utilised their own nursing network.

Previous studies on the EPA have rarely taken the existence of employment into account after candidates return to their home country as a deciding factor. Therefore, we would like to identify two contexts particular to the Vietnamese candidates on the basis of this fact.

The first of these contexts is that in Viet Nam, some companies that train and send care workers to Japan have recruited EPA care workers. This is because new migratory channels for elderly care have been developed in Japan (namely, the Technical Intern Training Program, international students in caregiving schools, and Specific Skilled Workers) since 2017. For example, according to Ms. A, her employment contract stated that her company duties were 'basic education in care work and Japanese language, curriculum creation for care work, etc.' and her salary included a 'care worker qualification allowance'. This kind of work fulfilled candidates' desire to utilise their unique experiences (as certified EPA care workers) in teaching others in Viet Nam. Informant 7 claimed, 'I want to be involved in education. [...] I

want to make the most of my four years of experience. [...] Some of the students I am teaching are graduates of nursing schools. One-third to one-half. I want to teach them so that they won't have any problems (in Japan).'

The second context is that the candidates considered Vietnamese young people's engagement in care work in Japan to be a positive choice. Informant 3 said, 'In reality (in Viet Nam), nobody is interested in care work. (But) if you go to Japan, you become interested.' Regarding their perceptions of the professional decision to shift from nursing to care work, Informant 1 shared, 'As the future society (of Viet Nam) will have increasing numbers of older people, I think that it will actually be necessary to do that job, so that people will not dislike care work. It will be like Japan.' Participants seemed to consider the shift in their career path, from nursing to care work, positively. This belief led them to consider teaching Japanese and care work to young people who wanted to go to Japan as rewarding work.

5. Conclusion

This study investigated EPA care workers' reasons for returning to Viet Nam and the current situation of the 17 participants from the first batch of EPA Vietnamese care workers who had returned to Viet Nam following their success in the national exam.

Due the sampling bias caused by the methodology of this study, we must be careful to apply the result of this study. Yet, this study indicated significant findings as follows.

As a result of the quantitative and qualitative surveys, the following three findings were revealed as the main reasons behind candidates' return to Viet Nam. First, the care work in Japan itself, the 'push factor', was not the main reason for returning to Viet Nam. Moreover, almost all participants stated their satisfaction with care work in Japan. Second, the important 'pull factors' for returning to Viet Nam were marriage and family (parent) care. In addition to Viet Nam's gender roles, we found that there is an aspect of taking responsibility of caring for their families because of being graduate nurses. Third, another important pull factor was their ability to find employment as teachers to train care workers who were going to Japan. It was also discovered that they found this employment opportunity through their professional networks. Furthermore, their decisions may also reflect their perceptions of the need for care work in Viet Nam in the future.

Future research should scrutinise why these JVEPA-certified care workers highly value the knowledge and skills learned in care work in Japan.

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Chapter 5

Developing an Oral Care Checklist

Susiana Nugraha and Yuko O. Hirano

This chapter reports on the development of an oral care checklist for Indonesian older people. The list is based on the list developed by Prof. Higashijima, which was developed in Japan (Higashijima and Watanabe, 2018). We modified it into a version that is suitable for the realities in Indonesia, in accordance with the healthcare, long-term care (LTC), and living environment of older people in Indonesia.

The reasons why we chose oral care as the topic of this study amongst the various forms of LTC practices are the following. First, oral health is one of the most significant factors in maintaining physical, mental, and social health. Needless to say, without eating, we could not live, but we do not eat just for surviving. Eating brings us pleasure and joy. It also creates opportunities to maintain social networks through eating with others. Thus, oral care is one of the key forms of care work to support the activities of daily living (ADL) and quality of life (QOL) of older persons. Second, oral care practices require some of the highest levels of care skills to control the critical risks, such as aspiration pneumonia and asphyxiation. As Japan has a history of providing oral care by various specialists, such as doctors, nurses, physical therapists, occupational therapists, nutritionists, and *kaigo* workers (care workers in Japan), many skills and much experience performing oral care have been accumulated. Third, anatomically and physiologically, the structure and function of the human body is universal, and therefore we speculate that a universal model of oral care can be easily established and disseminated globally.

1. Importance of oral hygiene

As we become aged, we lose physical abilities. Such a decline in physical abilities can cause difficulties with selfcare and affect oral hygiene, resulting in a loss of dental and oral cleanliness and health. In general, poor oral health has a negative impact on the QOL, health, and even the dignity of older people. The treatment, management, and prevention of oral diseases in older people will improve not only the conditions of their mouths but also their overall health and well-being (Ide et al., 2006). A number of oral diseases can be caused by smoking or poor control of diabetes mellitus. In this sense, oral diseases are relevant to systemic diseases (Razak et al., 2014). Some studies suggest that oral health is significantly related to the development of cardiovascular disease, as oral diseases trigger the inflammatory pathway (Tonetti et al., 2013). Good oral health has a strong positive effect on the nutritional intake of older people (Soini, 2003), and diet plays a key role in maintaining health. Petersen et al. (2018) show that poor oral health can have a significant negative impact on the QOL of older people and their ability to carry out daily routines. A Japanese epidemiological study using longitudinal data targeting a large population of older people has

shown that deterioration in oral health (i.e. a decrease in the number of teeth or an increase in oral health problems) can increase the risk of depressive symptoms in older people (Yamamoto et al., 2017). All this supports the importance of oral health later in life.

2. Care work in Indonesia (observation)

Before developing an oral care checklist for Indonesia, the authors of this chapter made observations on care facilities in Indonesia on 27 August 2018. We visited both government and private care facilities for older people. These facilities were deliberately selected by the Indonesian members of this study so that we could observe the different characteristics of care facilities for older people in terms of social status and the care practices provided in each facility, as described below.

2.1. Government-owned care facility

Panti Sosial Tresna Werdha Budi Mula 1 is a public care facility (*panti werdha*) where 210 older people were accommodated when we visited. Most of the older people in the facility could not be taken care of by their families or relatives or afford to have private caregivers. Amongst the 210 older people, 40% needed total care, 40% were independent, and 20% needed partial care. The classification of the functional status of the elderly was determined based on the results of the assessment of the Activity Daily Living scores using the Barthel Index and the Instrumental Activity Daily Living scores using the Lawton Index. The facility has a clinic where eight nurses work as full-time staff, and doctors make visits once a month. They also have volunteers visiting the facility occasionally. They organise spiritual activities once a week, where the older persons gather according to their faiths, such as Muslims or Christians. We were able to observe this activity by chance at the time of our visit. The older persons who were independent (not dependent on the care provided) participated in these spiritual activities.

The *panti werdha* does not have dining rooms, so the older persons who are totally dependent on the provided care are fed on their beds, whilst the independent older people eat outside their rooms, either sitting on a chair or on the floor. Edentulous older persons also eat by themselves, if possible. We found some older persons who did not sit up in their beds during our stay.

As one of our impressions from our visit, it seems that singing activities contributed to maintaining their ADL, facilitated the development of social relationships, and uplifted them spiritually. The older persons looked happy when they were singing, and some of them danced while singing. These activities definitely contribute to promoting the well-being of the older people.

2.2. Private care facility

Sasna Tresna Werdha Ria Pembangunan (RUSUN Lansia) is a private care facility founded in 1978 by the first lady of former president Soeharto as a welfare institution. It comprises care

facilities for older people, a midwifery school, and an orphanage. It is run by a foundation with five board members who work as volunteers and 46 staff, including 6 nurses, 3 social workers, 1 physical therapist, and (informal) caregivers. Currently, 68 older persons are living there, and most of them are from middle or upper-class backgrounds. The older persons can be accommodated in this *panti werdha* only if the will of the applicant (not the will of their family) to move to the facility is confirmed. The monthly payment of the older persons ranges from Rp800,000 to Rp6 million, including food. The monthly remuneration of nurses is Rp2.5 million, whilst caregivers receive Rp1.5 million. The turnover of staff is high. Although the study members could not observe feeding scenes at the time of our visit, we could see the older persons were actively involved with social activities like handicrafts or pleasantly talking to each other. We talked to a 94-year-old female older person. She maintained a high ADL, was totally independent, was able to speak English and some Japanese, and read a Dutch book. This indicated her high intellectual background. The *panti werdha* sells some of the craft products that the older persons make as part of their fund-raising activities.

3. Comparison between Japan and Indonesia in methods of care

Observing the above-mentioned care facilities in Indonesia, the authors of this chapter noticed the following points in a comparison between Panti Sosial Tresna Werdha Budi Mula 1 and an intensive care home for the elderly in Aichi prefecture, Japan, which the research team visited on 4 March 2019.

In this section, we try to make a comparison of the feeding care practices in both facilities, but it should be noted that the backgrounds of the older persons are quite different, as the older persons at *panti werdha* in Indonesia are selected based on the necessity of social protection of the applicants. Japan's intensive care homes for the elderly select the older persons (at least officially) solely depending on the care needs of the applicants, which are assessed through a universally used care assessment questionnaire. The care facilities for older people in Japan must be equipped with dining rooms separated from bedrooms, in accordance with the ministerial ordinance No. 40 announced by the Ministry of Health, Labour and Welfare on 31 March 1999 (Ministry of Health, Labor and Welfare, 1999).

3.1. Posture and position of caregivers

The caregivers in Indonesia seem to have more manpower and time to care for older persons than in Japan. Unlike in Japan, the posture and position of caregivers when feeding the older people were not uniform in Indonesia. Some were sitting, whilst others were standing in front of the older persons when feeding them. The facility does not have a dining room, so feeding takes place in the bedrooms (Figure 5.1).

Figure 5.1. Care Workers in Indonesia



Source: Photo taken by the author.

Figure 5.2. Kaigo Workers in Japan



Source: Photo taken by the author.

In Japan, when *kaigo* workers assist older people in the dining room, they sit in a chair beside or diagonally to the older person at eye level whilst supporting them, so that the *kaigo* workers are able to observe older person carefully, to check they are swallowing foods appropriately. As Japan's care facilities have dining rooms separated from the bedrooms, *kaigo* workers attend to the older persons more intensively than in Indonesia's care facility. If the older persons are able to walk by themselves to go back and forth between the bedrooms and dining rooms, *kaigo* workers need to make sure that they do not fall. If there are older persons who are unable to walk by themselves, *kaigo* workers must convey the older persons using wheelchairs to the dining room before their meals. Because of this, the meal preparation period in Japan's care facilities is hectic due to the lack of manpower and time (Figure 5.2).

3.2. Meal preparation period: Waiting for the food to arrive until the food is served

The older people in Indonesia lie on their beds during the meal preparation period (Figure 5.3). At the facility, there were some wheelchairs that were not in use, although they would have been useful in maintaining the older persons' posture whilst eating. When one staff member feeds an older person, another staff member holds the older person's back to maintain good posture, as shown in the left-hand picture of Figure 5.1. This type of care requires double manpower.

In Japan, all older persons were sitting in either a standard wheelchair or reclining wheelchair whilst waiting for the meals to be served, in accordance to the level of Activities of Daily Living of the older persons. The 'PATAKARA Taiso', or oral exercise, was instructed by a *kaigo* worker. The 'PATAKARA Taiso' is a self-managed exercise to strengthen the function of the throat to smoothly convey the food into the oesophagus after chewing. To do this, one pronounces 'PA-TA-KA-RA' to train the muscles of the mouth and throat (Figure 5.4).

Figure 5.3. Meal Preparation Period in Indonesia



Source: Photo taken by the author.

Figure 5.4. Meal Preparation Period in Japan



Source: Photo taken by the author.

3.3. Variation in the form of food

The form of food served in Indonesia was uniformly provided, and we observed that it was suitable for the potential swallowing functions and abilities of the individual older persons. We did not find any cases whose swallowing functions were below the ability that was necessary to swallow the food provided, so we would need to make further observations to find out how they feed older persons who are unable to eat the food provided at the care facility (Figure 5.5).

Figure 5.5. Form of Food (Indonesia)



Source: Photo taken by the author.

Figure 5.6. Form of Food (Japan)



Source: Photo taken by the author.

In Japan, a variety of forms of food were provided in accordance with the functions and abilities of the older persons, aimed at reducing the risk of aspiration and asphyxiation. In the care facility that we visited, not only the *kaigo* staff but the non-*kaigo* staff, such as human resource administrators, were also engaged in feeding the older persons, in accordance with the policy of the facility. On each tray, a tag with the name of the recipient was placed beside the food to indicate the swallowing functionality of the individual and the form of food. This system is designed to let every staff member know the information on the status of each older person, so that each staff member can provide appropriate care to the older persons (Figure 5.6).

3.4. Self-reliance whilst eating

We noticed that in the *panti werdha* in Indonesia, caregivers seemed to simply assist the older persons in eating, without assessing the potentiality of the older persons. It also seemed that the caregivers in Indonesia did not have the enough knowledge that the residual functions of the older persons should be utilised and increased by making them exercise in order to maintain their QOL. Prof. Higashijima found that a female older person who was being assisted by a caregiver to eat was able to eat by herself when the spoon was given to her by the professor herself. The woman, whose cognitive function was unimpaired, took the spoon with her non-dominant hand, as her dominant hand was paralysed, and was able to feed herself. Observing this, Prof. Higashijima assumed that this case could become independent from assistance by the caregivers after a short period of training (Figure 5.7).

In Japan, observed a scene where foreign *kaigo* workers provided care in accordance with the level of QOL of the individual older persons. As shown in Figure 5.8, the *kaigo* worker let the older person hold a spoon and assisted her so as not to drop the spoon. This method may help the older persons retain their residual abilities (Figure 5.8).

Figure 5.7. Self-reliance (Indonesia)



Source: Photo taken by the author.

Figure 5.8. Assisting Self-reliance (Japan)



Source: Photo taken by the author.

4. Modifying Higashijima's oral care list

After the visits to the care facilities, a workshop was held in URINDO on 28 August 2018 aimed at having discussions amongst local experts and the research team members on the merits and demerits of oral care practices in Indonesia and Japan as well as the possibility and validity of adopting an oral care assessment instrument in care facilities for older persons in Indonesia. The purpose of modifying Higashijima's oral care list is to compare the Indonesian care providers in Indonesia (caregivers) and in Japan (*kaigo* workers) in terms of implementing oral care when they assist meals, so that we can compare the implementation of oral care for older persons in the two different care settings, Japan and Indonesia. The result of the comparative study of the two groups will be shown in the next section.

In the workshop, after watching the video taken at Panti Sosial Tresna Werdha Budi Mula 1 and discussing what could be found from the feeding scenes there, the participants tried to establish an oral care checklist using the oral care list developed by Prof. Higashijima (Higashijima and Watanabe, 2018) as the prototype for the discussion. Since Prof. Higashijima developed the list in the context of the Japanese care facilities for the purpose of providing ideal oral care and feeding support for caregivers in care facilities, it should be modified to be compatible with the care practices and conditions in Indonesia. Finally, the participants selected the most appropriate items to be put in the oral care checklist for Indonesia's version with some modifications, though Higashijima's original list has 92 items (Higashijima and Watanabe, 2018). Higashijima's modified oral care checklist (modified Higashijima-oral-care-list) and the results of the comparative survey are shown in Table 5.2.

5. Comparative survey of oral care performance in Japan and Indonesia

Taking the example of Indonesian care workers engaged in care work in Indonesia and Japan, we conducted a questionnaire survey to find out how the act of care differs from country to country. In this section, a statistical comparison between Indonesia and Japan will be shown on what kinds of oral care practices are provided to the older persons. The questionnaire was comprised of background information on the respondents and the modified Higashijima-oral-care-list. We asked if they could make observations and confirmations for each item of the list during their actual oral care practices in their workplaces. For each item, we computed the proportions of the respondents who replied that they surely practiced what is mentioned in the item, and we call this the 'performance rate'. We compared the two groups to find the differences in the oral care performed in both countries.

5.1. Sampling of the study participants

In Indonesia, nonprobability purposive sampling was performed to select the participants. In total, 215 care workers from 18 care facilities (7 government-owned facilities and 11 privately owned facilities) and four prefectures (Yogyakarta, West Java, DKI Jakarta, and Tangerang Banten) were enrolled in the study. Data collection was conducted from September 2018 to January 2019. A paper-based questionnaire asking about social-demographic characteristics and the modified Higashijima-oral-care-list was distributed and collected at the site. The

response rate was 100%. In Japan, a total of 418 Indonesian *kaigo* workers who worked in Japan at that time were called for participation in the study through SNS. An online survey was conducted, and 120 respondents answered the questionnaire. The response rate was 28.7%. The characteristics of the participants by country are shown in Table 5.1.

Table 5.1. Characteristics of the Respondents

Characteristic	Indonesian caregivers in Indonesia (<i>n</i> = 215)	Indonesian <i>kaigo</i> workers in Japan (<i>n</i> = 120)
Age (SD)	35.2 (11.2)	27.9 (3.1)
Length of work by year (SD)	7.3 (6.8)	3.7(2.8)
Gender (%)		
Female	134 (62.3)	83 (69.1)
Male	79 (36.7)	37 (30.8)
Academic background (%)		
University/college/STIKES graduate	73 (34.3)	120 (100)
High school graduate	98 (46.0)	-
Secondary school graduate or lower	42 (19.7)	-
Occupation at the care facility		
Nurse	52 (24.2)	-
Caregiver	151 (70.2)	120 (100%)
Cadre	1 (0.5)	-
Others	11 (5.1)	-

STIKES = Sekolah Tinggi Ilmu Kesehatan (Polytechnic College for Healthcare Professionals).

Notes: All of the Indonesian *kaigo* workers in Japan had finished the nursing course. A cadre is a community health volunteer.

Source: Original data of the author.

5.2. Differences in oral care practices between the two countries

We scored the number of items for which the respondents replied, ‘Yes, I usually make an observation and confirmation of what is stated in this item.’ Table 5.2 shows the differences in the scores for each category provided by the modified Higashijima-oral-care-list between caregivers working in Indonesia and Indonesian *kaigo* workers in Japan.

Table 5.2. Comparison of Oral Care Checklist Scores Between the Two Study Groups

No	Observation item	Japan (n = 110)	Indonesia (n = 213)	P value
I	ENVIRONMENTAL OBSERVATION			
1	There is a separation between the dining room and the bedroom.	96%	55%	< 0.001
2	Adjustable dining tables or special chairs that can be used according to needs are available for personal use.	91%	47%	< 0.001
3	There are applicable utensils (e.g. spoons and chopsticks) that can be used in accordance with the impairment of the individual user.*	98%	-	
4	There are variations in the form of food (e.g., porridge cut into bite-size pieces and soft chopped food).	98%	64%	< 0.001
5	There is portable mucus suction.	77%	54%	< 0.001
6	There is a tool that can be used by care workers or patients to notify other care workers if there is an emergency (e.g., a bell).	89%	44%	< 0.001
7	The numbers of care workers and older adults are balanced when conducting meal supervision.	66%	52%	0.008
8	There is an allocation of one care worker for every older people who requires total care.**	28%	60%	< 0.001
9	The care workers understand the dietary needs of each older person.	78%	74%	0.257
	Total score	6.2 (SD:1.4)	4.5 (SD:1.9)	< 0.001
II	OBSERVATION OF FUNCTIONS AND EATING CAPABILITIES			
A	Overall condition before eating			
1	Older adult moves differently than usual.	72%	58%	0.009
2	Older adult is in a poor condition or has sleep deprivation.	42%	57%	0.006

3	Older adult has fever.	20%	50%	< 0.001
4	Older adult is in a state of coughing.	27%	43%	0.004
5	Older adult has different blood pressure (higher or lower) and pulse (bradycardia, tachycardia) than usual.	36%	49%	0.012
	Total score	2.0 (SD:1.4)	2.6 (SD:2.0)	0.021
B	Meal preparation period: Waiting time for food to arrive until food is served			
1	Older adult cannot sit in a stable position.	66%	54%	0.018
2	Older adult is not fully conscious.	39%	41%	0.428
3	Older adult appears calm.	40%	55%	0.008
	Total score	1.5 (SD:1.2)	1.5 (SD:1.2)	0.839
C	Feeding period			
1	The dining table cannot be set up in accordance with the bodily positions of the older adult.	82%	49%	< 0.001
2	There are difficulties when eating (e.g. cannot use a spoon for food or hold food).	79%	65%	0.007
3	There are problems in paying attention to food and the environment.	77%	55%	< 0.001
4	There is a problem when placing food into the mouth (e.g. handshakes or food falls).	72%	67%	0.207
5	There is a speed problem when placing food into the mouth.	72%	55%	0.003
6	There is a problem with the amount of food that is placed into the mouth.	68%	55%	0.014
7	Older adult cannot ask for help when having difficulties during the eating process.	55%	44%	0.035
8	Older adult refuses to be helped when eating (e.g. does not want to open their mouth or feed themselves).	63%	49%	0.014

	Total score	5.7 (SD:1.9)	4.4 (SD:2.9)	< 0.001
D	Swallowing period			
1	Older adult cannot take in food smoothly (e.g. lips cannot close, or food falls out of the mouth).	58%	54%	0.302
2	There are problems with chewing (e.g. lack of chewing, removing or leaving hard food, very fond of eating soft food only, or chewing for a long time).	70%	66%	0.287
3	Older adult cannot chew food into appropriate shapes and sizes to be swallowed.	59%	59%	0.520
4	Older adult hoards food in the mouth (e.g. stores food in the mouth but does not swallow).	65%	57%	0.083
5	There are problems with the process of swallowing food (e.g. cannot swallow food or takes time to swallow food).	71%	54%	0.002
6	There is a swallowing disorder (e.g. food cannot be channelled into the oesophagus).	48%	48%	0.535
7	There is a sound of fluid in the oesophagus.	43%	47%	0.300
8	Older adult is choking when eating.	59%	56%	0.362
9	Older adult does not exhibit coughing when choking.	39%	54%	0.009
10	Older adult takes a lot of time from start to finish when eating.	81%	60%	< 0.001
11	Older adult looks tired when eating.	48%	49%	0.503
12	Older adult looks weak when eating and cannot maintain proper posture (e.g. the body position is always slumped).	66%	53%	0.018
13	Older adult does not finish one portion of the provided food.	72%	55%	0.002
	Total score	7.8 (SD:3.7)	7.1 (SD:4.5)	0.216

E	Post-meal period			
1	Older adult does not brush teeth after meals.	41%	32%	0.070
2	There is shortness of breath after meals.	29%	45%	0.005
3	Older adult cannot use toothbrush.	66%	40%	< 0.001
4	There is leftover food after brushing teeth.	69%	40%	< 0.001
	Total score	2.1 (SD:1.3)	1.6 (SD:1.2)	<0.001

Source: Original data of the author

*/**: These items were omitted from the questionnaire for Indonesian care workers in Indonesia

The results indicate that Indonesian *kaigo* workers in Japan are more likely to perform environmental observations than Indonesian caregivers ($p < 0.001$). They were more likely to check the items in the oral care lists during the feeding period and post-meal period ($p < 0.001$, respectively) than their counterparts.

On the other hand, Indonesian caregivers were more likely to check the overall condition (including physical and mental soundness) of the older persons before eating ($p=0.021$) than Indonesian *kaigo* workers in Japan. We discussed what factors contributed to such differences and concluded that the following four points had affected the results.

First, Japan has the Long-Term Care Insurance Act, and almost all the care facilities in Japan are accredited by this insurance system, and the cost of their services are covered by the insurance under the conditions that they comply with the regulations of the insurance system. Accordingly, Indonesian *kaigo* workers at such care facilities are working under such regulations. For example, an Intensive Care Home for the Elderly must have dining rooms or must be equipped with apparatus or other instruments that meet the physical needs of the older people, in accordance with the regulations enforced by the ministerial ordinance (Ministry of Health, Labor and Welfare, 1999). This may result in Indonesian *kaigo* workers being more likely to answer that they check the environment of the care facility than their counterparts working in Indonesia.

Another point is that caregivers working in Indonesia seem to have more time to pay attention to the conditions of the older persons, probably because a higher number of care workers are assigned per each older person, especially for older persons who are totally dependent on care for their activities of daily living, in Indonesia. We suppose this factor contributed to the higher performance rates of caregivers in Indonesia for the items in category II-A (the items that should be checked before eating).

The third point is that these results may indicate differences in care providers' roles in the care facilities, which may be subject to the regulations of the LTC system in each country. In Japan, *kaigo* workers work together with other specialists, such as nurses, so the work in care

facilities is shared in accordance with occupation categories. Checking whether the older persons have a fever, suffer from coughing, or display other irregular conditions is the responsibility of nurses in Japan. Indonesian *kaigo* workers in Japan, therefore, are likely to focus on the job descriptions assigned to them, for example, managing the timing of bringing food to the mouths of the older persons. Such work sharing, however, sometimes leads the *kaigo* workers in Japan to pay less attention to the holistic approach for older persons. Treating the older persons through a holistic approach is a significant point of the care. In this context, Indonesian caregivers have an advantage over their counterparts in Japan.

Lastly, the researcher must consider that, in this study, the data were obtained through self-rated questionnaires that reflect the subjective view of each respondent, which may have caused data bias.

Further study is required to find out the factors contributing to such differences between the two countries, especially regarding the role of caregivers in Indonesia who engage in care work that may overlap with the role of nurses. In addition, we must keep in mind that the demarcation of assigned duties between nurses and caregivers in Indonesia is different from that in Japan. It is necessary to take this background into consideration for us to further modify the oral care lists to suit the culture of care in each country.

6. Conclusion and policy recommendation

This study developed a modified oral care checklist based on the Japan-developed list that is suitable for use in Indonesia, and, using this checklist, compared care between Japan and Indonesia by examining the performance rates of each item included in the oral care list. Considering the concept of Japan's Long-Term Care Insurance Act, which was enacted aiming to maintain the dignity and independent daily life routines of people who need LTC (Ministry of Health, Labor and Welfare, n.d.), the researchers hypothesised, especially at the outset of this project, that *kaigo* workers in Japan are more likely to attend to every aspect of their work, with broader attention to the physical and mental conditions of the older people. However, the results did not fully support this hypothesis. Indonesian care workers in Indonesia attend even more broadly to the older people through a holistic approach, including checking their vital signs, than their counterparts in Japan.

From the perspective of medical sociology, the role of the medical profession emerges in accordance with the needs of the society. As mentioned in Chapter 1, the certification system of *kaigo* workers was established in Japan in response to the demand for professional caregivers in the course of rapid population ageing, which requires 'socialisation of care' (a shift from family caregivers to professional caregivers). In societies with 'socialisation of care', only fewer care personnel can provide care to each older person than the societies which still have family-care-system. In Indonesia, contrary to Japan, family members are the main caregivers for the older people, as Indonesia has not yet entered the era of socialisation of care.

Generally speaking, the role of the profession develops in accordance with social change, as does the division and specialisation of labour. The conceptualisation of care work can take place in line with such development of occupation categories. Japan developed the concept of care work earlier than Southeast Asian countries like Indonesia, and the Japanese government launched a policy to promote the transfer of LTC technology. However, in this context, Japan cannot be too careful in 'transferring' the concept of care, or care methodology, through a one-sided perspective because such a concept is supposed to emerge differently in countries with different social and cultural backgrounds. In this study, we just targeted in-facility caregivers, but we realise this method cannot fully detect the social change that will influence the conceptualisation of care work. If we have a chance to conduct further study, we will target not only in-facility care workers but also family caregivers.

Lastly, we would like to suggest that optimising the current environment (without introducing any new equipment) is important to improve the quality of care in Indonesia. For example, utilising wheelchairs during mealtimes as backrests is effective in keeping good posture for swallowing, which enables older persons to swallow properly. This small modification can even save manpower because it requires only one caregiver to support one older person who cannot eat by themselves, unlike in the care facility in Indonesia, where one caregiver took the food to the older person's mouth, and another kept their posture. Such small suggestions to optimise the current care conditions are important for the stakeholders of LTC to interact internationally with respect for the local care environment, so as to develop tools and training packages to strengthen the capacity of formal and informal caregivers.

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