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Human Resource Development, Employment, and International Migration of Nurses and Caregivers in Asia and the Pacific Region

Edited by

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Preface

An increasingly ageing population in many developed countries has contributed to greater demand for nurses and care workers. As these countries cannot meet growing demand domestically, they seek to recruit nurses and care workers from abroad. According to the latest statistics from the Organisation for Economic Cooperation and Development (OECD), 15.8% of nurses and 28.5% of home-based care workers in OECD countries were born abroad.

Asia is a major source for migrant nurses and care workers; at the same time, certain countries within the region have a demand for them. The number of nurses per population in Asian countries from where they migrate is often much lower than that in the destination countries. The worldwide shortage and imbalance of nurses and care workers have only been exacerbated by the coronavirus disease (COVID-19) pandemic.

As the shortage of nurses and care workers in the destination countries is often structural, many countries try to retain migrant nurses and care workers for a longer duration by adjusting the regulatory framework of immigration and health and labour and employment policies every so often. The World Health Organization Global Code of Practice on the International Recruitment of Health Personnel promotes ethical international recruitment of health personnel. This code aims to strengthen health systems and safeguard the rights of health personnel, particularly from developing countries, whilst recruiting them. With growing demand for healthcare workers because of the COVID-19 pandemic, difficulties arise in recruiting healthcare personnel to achieve universal healthcare coverage, one of the targets set under the Sustainable Development Goals.

International recruitment of nurses and other care workers is often associated with ‘brain drain’, where developing countries lose trained healthcare personnel to developed countries, and ‘brain waste’, where trained nurses in source countries are employed as care workers for the elderly in destination countries. The challenge is to convert the situation into a ‘mutually beneficial outcome opportunity for all’. Another problem arises when nurses and care workers returning to their country of origin are expected to impart their skills and knowledge to others. As a result, some updated technical skills and language proficiency skills of the returned workers’ become underutilised.

This volume aims to explore how mutual benefit can be achieved in the post–COVID 19 pandemic era. It is important to understand the dynamically changing situations and challenges in training and employment of nurses and care workers in source and destination countries.

To comprehend the different perspectives of the source and destination countries of nurses and care workers, this volume includes Cambodia, India, Indonesia, Malaysia, the Philippines, and Viet Nam representing the source countries; and Australia, New Zealand, and Japan representing the destination countries. Nurses and care workers in destination countries were included in the analysis, as some care workers in these countries were nurses in their country of origin. Although each chapter's approach to migrant nurses and care workers is different, the volume tries to determine the diversity and common features of recruitment, consequences, effects, and policy responses of the migrant nursing and care workforce in Asia.

As the second collaborative work of the Institute of Developing Economies–Japan External Trade Organization and the healthcare unit of the Economic Research Institute of ASEAN and East Asia, this research project commenced in April 2019. However, it was disrupted by the global COVID-19 pandemic for some time. As it was difficult to conduct in-person interviews, surveys, and meetings, we have done our best to adopt alternative virtual methods. We are delighted to have delivered this volume.

Finally, we are grateful to all those who helped and supported this project. In particular, we express our deep appreciation to the frontline nurses, care workers, and all the people who took the time to respond to our enquiries. They did so whilst struggling to save lives and sustain the health and care system for the elderly amidst the COVID-19 pandemic. We would be more than happy if this volume could contribute to the understanding of dynamically changing human resource development, employment, and international migration of nurses and care workers in the Association of Southeast Asian Nations (ASEAN)+6 region and facilitate further research.

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Chapter 1

Emerging Issues in the Implementation of the *Kaigoryugaku* (Study) Scheme for Foreign Care Workers in Japan: The Case of the Philippines*

Ma. Reinaruth D. Carlos

Yurika Suzuki

In response to the serious present and near-future manpower shortage in the long-term care sector, Japan has been slowly opening its labour market to foreign workers through the recent introduction of several employment schemes. This report focuses on the kaigoryugaku (study) scheme or pathway, introduced in 2017, in which international students who graduated from a training school for certified care workers in Japan are employed and granted 'nursing care' (kaigo) status of residence. We discuss two major sets of issues: (i) the current onsite problems encountered by stakeholders in training institutions: teachers, Japanese and international students, and administrators and staff; and (ii) the emerging concerns of future employers and graduates. Finally, we suggest some policy interventions and explore the implications of Japan's current employment policies on its labour market for care workers.

1. Introduction

More than any country, Japan faces the serious issue of how to care for its elderly amidst its declining population. According to the Statistics Bureau of Japan (n.d.), about 29% of the population was 65 years old and above (the elderly), and 14.9% was 75 and above as of 1 October 2020. This proportion exceeds that in all other countries and, by 2040, 1 out of 2.8 residents (35.3% of the total population) is projected to be elderly.

The country's households are ageing. Households with at least one member aged 65 and above comprise 49.4% (25,580,000) of the total number of households in 2019 (Cabinet Office Japan, 2022). By 2040, it is projected that it will further increase, particularly the figure for single-member elderly households.

As the elderly population ages and more live independently, demand for care provided by non-family members expands. In Japan, demand for long-term care[1] services is based on the 'certification of long-term care needs', a five-level graded classification that evaluates elderly persons using a set of physical

* This paper presents the research results of fieldworks supported and funded jointly by Institute of Developing Economies– Japan External Trade Organization and Ryukoku University Socio-cultural Research Institute. All views expressed in this paper are solely the responsibility of the authors.

[1] Various terms are used to mean care for the elderly, such as 'caregiving', 'elderly care', 'care work', and 'long-term care'. Here, we use the terms interchangeably and as written in the literature.

and mental health indices, implemented under the long-term care insurance system. The number of certified elderly persons comprised 18.8% of the total elderly population in 2020 (MHLW, 2022a). This ratio registered only a slight increase from previous years, which can be attributed to the government's efforts for preventive long-term care and the revision and the stricter implementation of the certification classification system.

Another factor contributing to the higher demand for long-term care services is the rise in the number of dementia patients. Koyama et al. (2019) noted that the number of elderly people diagnosed with dementia jumped from 681.9 per 100,000 people in 1999 to 2,029.5 per 100,000 people in 2014. A Kyushu University study (Nikkei Asian Review*,* 2019) reveals that by 2025, 20.6% (7,300,000) of all seniors will be diagnosed with dementia. Dealing with dementia patients is one of the concerns of foreign care workers, partly because not many elderly in their home countries are diagnosed with this disease.

From 2000, when the Long-Term Care Insurance Act was implemented, until 2016, the number of workers in long-term care increased 3.3 times. Yet, in 2016, there was a shortage of 70,000 workers (Japan Foundation for Aging and Health, 2016). The Ministry of Health, Labour and Welfare (MHLW) (2015) estimated that the shortage would rise to 377,000 in 2025. The serious imbalance is reflected in the national ratio of job openings to seekers, standing at 4.31 for long-term care against an average of 1.60 for all sectors in 2019 (MHLW, 2022b).[2]The situation is worst in Tokyo (7.05), followed by Aichi (6.16), Gifu (5.93), and Osaka (5.18) prefectures (MHLW, 2019). As in many other destinations, care workers in Japan complain about low pay, poor working conditions, and severe labour shortage. (For details about conditions of care workers and care work institutions in the country, see, for example, Care Work Foundation [2019]).

Driven by the reasons above, the Abe administration embarked on a bold, intensive, and comprehensive campaign consisting of five major policy sets to attract and retain workers in long-term care. Local workers were given a monthly salary incentive amounting to JPY12,000 from April 2015 and an additional JPY10,000 per month from April 2017 (MHLW, 2017). The government implements subsidised training programmes for unemployed mothers, middle-aged persons, and other potential workers. It encourages information technology companies to develop long-term care robots and to adopt information and communication technology in the workplace.

One of the five policy sets is the opening of the labour market to foreign care workers. Four employment schemes or pathways are in place: bilateral economic partnership agreements (EPAs); the 'nursing care' status of residence, which is a working visa granted to graduates of a training school for certified care workers in Japan (*kaigoryugaku*); the technical training internship programme (TITP) in care worker occupation; and, more recently, the specified skilled worker category 1 (SSW[1]) in nursing care. We examine *kaigoryugaku*, which has gained popularity amongst Japanese stakeholders as an alternative to EPAs, especially in developing skilled and culturally competent human resources in long-term care.

Our study investigates the case of students from the Philippines. Amongst Japan's source countries, it has the longest history of sending its nationals overseas as care workers, particularly women and nursing graduates. Their destinations are the most varied. In long-term care, they are employed in

[2] The figures decreased to 3.60 for long-term care and 1.13 for all sectors in 2021 due to the COVID-19 pandemic (MHLW, 2022b).

Canada, Italy, and Singapore as caregivers, mostly at homes of the elderly, and as nursing aides and caregivers in nursing facilities and care homes in Australia, New Zealand, and the United States. In Japan, whilst they do not comprise the biggest proportion of recent arrivals of care workers, long-term resident Filipinos have been participating in this labour market since the early 2000s and have earned a positive reputation amongst the elderly and employers (see, for example, Carlos [2005]).[3]

As Japan opens its door more widely to foreign care workers in such a short time, the immediate concern is how Japanese stakeholders deal with practical issues. Given their limited or lack of experience and knowledge about the multicultural workplace and dealing with foreigners, confusion and cultural misunderstandings are inevitable. The experiences in *kaigoryugaku* scheme are similar to those under the bilateral EPAs during the first few years of their implementation. This time, however, the space of interaction amongst stakeholders has shifted from the workplace to learning institutions (training institutions), and the stakeholders (including co-workers, managers and employers, and elderly residents) to (initially) teachers, classmates, and school authorities.

We attempt to answer the following questions. First, what are the trends in implementing the four schemes and how do they differ from each other? Why is *kaigoryugaku* preferred over the three other schemes? The answers are in sections 1 and 2. Second, what are the current and emerging issues and concerns in the education of international students enrolled in care work training institutions (sections 3 and 4)? Third, and finally, what are the possible, feasible, and sustainable solutions to these issues? What are the implications of these issues on Japan's labour market in long-term care? The answers to the last two questions are in section 5.

We base our results on our investigation of two cases: one in north-eastern Japan (fieldwork conducted in October 2019) and another in south-western Japan (fieldwork conducted in December 2019). We interviewed Filipino students and Japanese students, instructors, and support staff in two junior colleges' certified care worker departments (cases A and B) (for their profiles, see Table 1.1), as well as several future employers of the Filipino students. We observed classes. A symposium in Kyoto on 2 February 2020 evaluated the EPA, identified concerns and issues regarding *kaigoryugaku*, and discussed lessons from the EPA and possible improvements in implementing the scheme. We also interviewed a representative from the Philippine Overseas Employment Administration (POEA)[4] and a labour migration specialist in the Philippines (February 2020) to gain a more comprehensive view of the country's emigration policies, particularly regarding the direct-hire ban. These research activities, from which we derived our findings, were conducted jointly with Ryukoku University Socio-cultural Research Institute research project (FY2018–FY2019).

[3] In Japan, workers engaged in long-term care are called *kaigoshi* but they are further classified based on their skills. There is no minimum required education or training to land a job as a *kaigoshi* but completing the care worker induction course (*shoninsha kenshu*) and passing the national examination for certified care worker (*kaigofukushishi shikaku*) are preferred.

[4] Renamed as Department of Migrant Workers (DMW) in 2022. Throughout this report, we will retain the former name, POEA.

Table 1.1. Profile of Case Studies

Case Study	Training Institution A (North-eastern Japan)	Training Institution B (South-western Japan)
Type of training institution	Junior college (2 years)	Junior college (2 years)
Year of establishment of care work course	2019	2010
Student admission quota per year	40	20
Total number of first-year students	10	19
Number of first-year Filipino students	4	4

2. Recent Trends in the Employment of Foreign Care Workers

There are four official labour migration schemes in which a foreigner can be deployed to Japan as a care worker.5 The oldest is the EPA, under which the deployment of foreign care workers is guided by a bilateral comprehensive economic agreement between the sending country and Japan. Since 2017, graduates of a certified care worker training school in Japan have been granted kaigo (nursing care) status of residence. From November 2017, the TITP was expanded to include care work. Under this scheme, workers from developing countries come to Japan to acquire skills to be brought back to their own country. Finally, in April 2019, the SSW(1) in nursing care started to be implemented to allow foreign workers who have passed skills and language tests before coming to Japan to work for several years (MHLW, 2020a). The key similarities and differences are summarised in Table 1.2.

[5] In addition, there are also foreign care workers whose status of residence is permanent, long-term or dependent (either of a Japanese national, a permanent or long-term resident, or a foreigner with a working visa).

Table 1.2. Four Schemes for Employing Foreign Care Workers from the Philippines (as of March 2019)

Type of Scheme Or Pathway	**1. Economic Partnership Agreement (EPA) (from 2008)**	**2. 'Nursing Care' Status of Residence for Foreign Students *(Kaigoryugaku)* (from Sept. 2017)**	**3. Technical Intern Training Programme (TITP) in Care Worker Occupation (from Nov. 2017)**	**4. Specified Skills Worker in Nursing Care (SSW1) (from April 2019)**
Objective	Economic cooperation	Education and employment	Skills transfer	Alleviation of labour shortage
Status of Residence (visa)	'Designated activities' (EPA)	'Nursing care' ('Student' whilst attending care worker training school)	'Technical intern trainee' (TIT) 1, 2, 3	'Specified skilled worker (1)' (SSW[1])
Allowed period of stay in Japan	As EPA: 4 years (+ 1 year extension). Renewable if certification is obtained	5 years, 3 years, 1 year or 3 months. Renewable	3 years for TIT 1 and 2. Can be extended for 2 years (TIT 3). Maximum of 5 years	1 year, 6 months, or 4 months. Renewable for a total of 5 years
Education or skills requirements at the time of entry to Japan	Graduate of nursing or 4-year course and Philippines' caregiver certification (NCII)	At least high school graduate (12 years of schooling)	Experience in similar job or close relationship between home country and Japan employers	Pass pre-arrival tests for long-term care skills for SSWs. Post-EPA or former TIT workers are exempted from language and skills tests
Language requirements at the time of entry in Japan	Not required. (Candidates are given 6–12-month language training before entry)	About Japanese-Language Proficiency Test (JLPT) N2 level (or enrolment in a Japanese-language school for at least 9 months)	About JLPT N4 level at time of entry and N3 during stay in Japan	Pass the Japanese-language exam for SSWs and JLPT N4 level
Certification examination	Qualified to take it from fourth year after entry. Must pass to stay in Japan	Qualified after completion of 2-year care worker course (exempted if works in Japan for 5 years)	Voluntary (if passed, status of residence is converted to 'nursing care')	Voluntary (if passed, status of residence is converted to 'nursing care')
Availability of support organisations as required by law	Yes (Japan International Corporation of Welfare Services [JICWELS])	None (schools look after students)	Yes (supervising organisation or individual enterprise)	Yes (Registered supporting organisation)
Family members can apply for 'dependent' status of residence	Yes (after certification is obtained)	Yes	No	No
Recruitment/ Deployment	Philippine Overseas Employment Administration	No specific restrictions, usually facilitated by study-	Supervising or implementing organisation accredited by POEA	Accepting organisation or dispatch company verified by POEA

	(POEA) and JICWELS (matching)	abroad companies or language schools		

Source: Authors' compilation from documents published by the Ministry of Health, Labour and Welfare (MHLW).

From the implementation of the EPA scheme until FY2019, a total of 5,026 care workers—1,967 coming from the Philippines[6] and the rest from Indonesia and Viet Nam—arrived in the country. As of June 2019, there were 4,166 care workers (including EPA candidates and license holders) holding the 'designated activities (EPA)' status of residence, comprising of 1,578 Filipinos, 1,657 Indonesians, and 929 Vietnamese (Statistics Bureau of Japan, n.d.). One of the major issues amongst Filipino EPA candidates is their poor performance in the certified care worker's national licensure examination.[7] Of the 657 Filipino EPA candidates arriving between FY2009 and FY2015 who took the said examination, only 330 or about half were able to pass it (MHLW, n.d.a).[8] Although the latest figures are not publicly available, a low retention rate is noted even amongst those who obtained the certification. Many left for other destinations, such as Canada, or returned to the Philippines. These trends imply that the EPA scheme has a limited impact on the labour market for long-term care.

The TITP scheme aims to transfer long-term care skills overseas; interns are required to return to the home country after a maximum of 5 years. To become interns, foreign workers must apply with a supervising organisation that fields them to nursing homes and institutions. They must prepare a plan containing the time frame and content of their training. Partly because it was implemented only in late 2017, it has a modest impact on the labour market. As of March 2019, 1,823 technical intern training plans were accredited, of which 35.82% were from Viet Nam, followed by Indonesia and China (Organization for Technical Intern Training [OTIT], 2020).[9] In the case of the Philippines, only 13 plans were accredited by OTIT by March 2019 because the Philippines government was late in issuing implementation guidelines (POLO Tokyo, 2018a).

The SSW(1) is Japan's first foreign care worker employment policy that explicitly states 'the alleviation of labour shortage' as its objective (Table 1.2). The 'semi-skilled' recruited workers are allowed to work full-time after arrival and with minimal pre-entry on-the-job training. The care workers must pass the long-term care skills evaluation and two language proficiency tests before their deployment to Japan. The scheme requires longer preparation in the home country than other schemes.[10] As of 19

[6] Excluding the 37 candidate care workers who arrived as students.

[7] This annual national examination is administered by the Social Welfare Promotion and National Examination Center and is in Japanese. The 125-item, multiple-choice examination comprises questions from 11 areas of long-term care (Social Welfare Promotion and National Examination Center website, n.d.). For the 2020 examination, 36.5% and 29.4% for EPA candidates from Indonesia and the Philippines, respectively, were successful. The passing rate for Vietnamese EPA candidates is 90.8% and 69.6% for others (foreign non-EPA candidates from overseas and Japanese).

[8] EPA candidate care workers are allowed to sit for the examination only in their fourth year of employment. If they fail in their fourth year, they are allowed to extend their stay and retake it in their fifth year. If they fail again, they must go back to their home country but are allowed to return to Japan to retake the examination. The total numbers of those who pass the examination and hold the certification are cumulative.

[9] A person who seeks to conduct technical intern training must prepare a technical intern training plan and receive accreditation of the suitability of the plan from OTIT.

[10] Based on an interview with a president of a sending organisation in Manila, the preparation period usually takes a year when the aspirant has no Japanese-language skills.

December 2019, POEA had approved 275 sending organisations for technical interns and specified skills workers (POLO, 2020), many of which offer pre-departure skills and language training. The SSW scheme gained immediate popularity in sending countries and, in only 9 months, the number of qualified applicants had exceeded 2,000. From April 2019 to February 2020, a total of 4,491 sat for the long-term care skill level evaluation and 2,207 succeeded, whilst 2,238 out of 4,316 passed the long-term care Japanese-language evaluation test (MHLW, 2020c).

The Philippines was the first source country where the monthly test was administered (April 2019). Within 11 months, 1,462 and 1,370 Filipino examinees had passed the long-term care skills and the Japanese-language evaluation tests, respectively (MHLW, 2020c). The same monthly exams have been available to aspiring care workers in Cambodia, Indonesia, and Nepal since October 2019, and in Mongolia since November and December 2019. Myanmar's first examination was held in February 2020. As of March 2020, however, there were no official statistics on the number of care workers deployed from the Philippines because the guidelines set by the Philippines government were announced only on 26 November 2019 (POLO Tokyo, 2019).

Japanese stakeholders involved in the SSW(1) scheme noted, however, that the deployment of SSW workers from the Philippines has not progressed at all because of 'bureaucratic' procedures, 'miscommunication', and slow and insufficient discussions between the governments of Japan and the Philippines on the implementation guidelines (NHK, 2020).

The study scheme is welcomed by stakeholders for its potential to produce highly skilled care workers. The number of international students enrolled in certified care worker training institutions dramatically increased, from 17 in FY2014 to 591 in FY2017, 1,142 in FY2018 and 2,037 in FY2019 (Figure 1.1a).[11] These numbers, however, are not expected to increase as much as those for the temporary TITP and SSW because of the hefty tuition fees and opportunity costs. One of the main problems in sustaining the study scheme is how to support the students financially through, for example, scholarships or subsidies.

[11] As most students take up language courses in Japan before enrolment in a certified care work school, the number of care work graduates and enrolees is expected to increase following reports of an increasing number of international students enrolled in language schools.

Figure 1.1a. Trends in the Admission of Students (New Enrolees) in Certified Care Worker Training Institutions (no. of students, FY2014–FY2020)

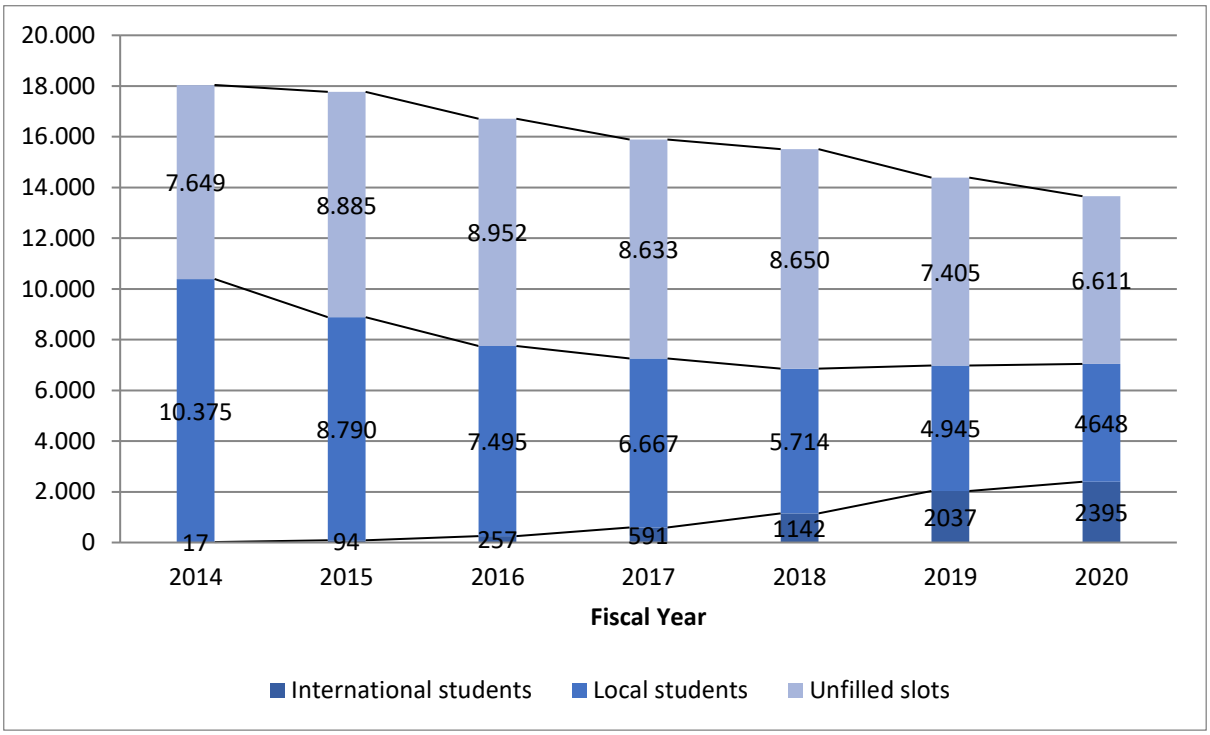
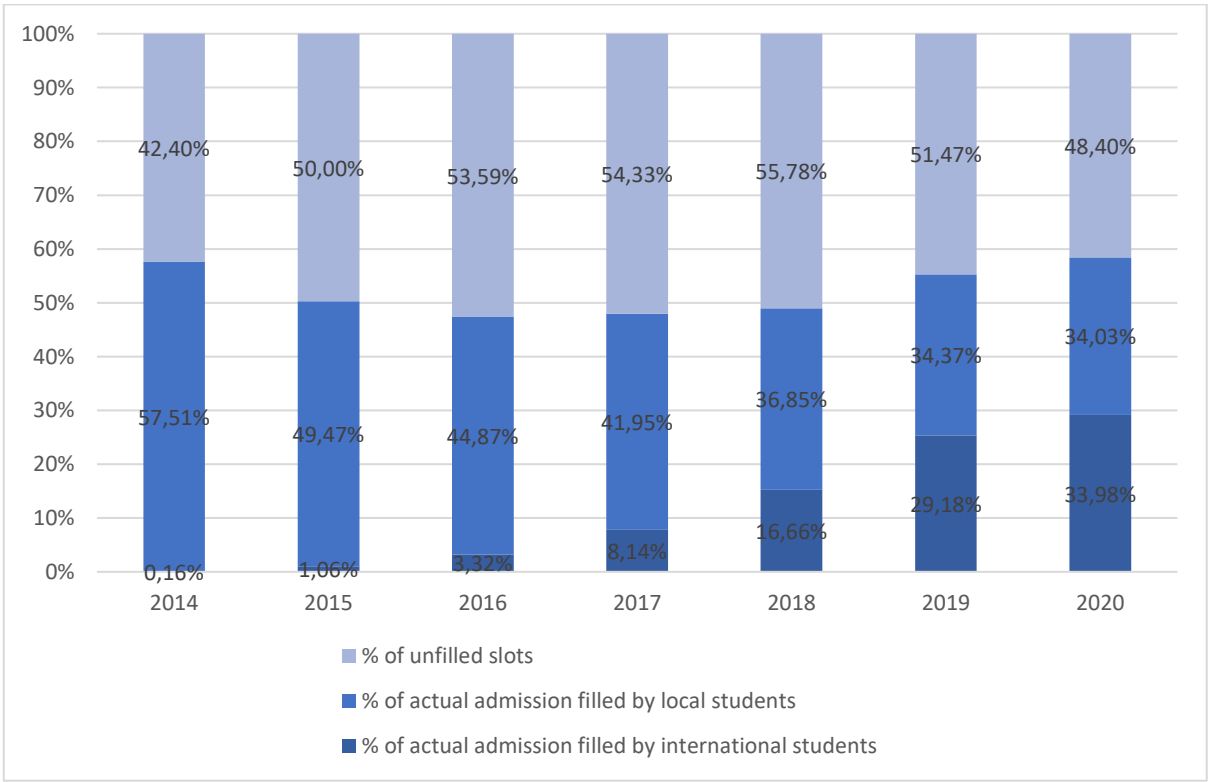


Figure 1.1b. Trends in the Admission of Students (New Enrolees) in Certified Care Worker Training Institutions (as share of total admission quota, FY2014–FY2020)



Source: Authors' compilation from Japan Association of Training Institutions for Certified Care Workers (2018 and 2021).

The nationalities of international students enrolled in certified care worker training institutions have diversified from only 9 countries in FY2015 to 26 in FY2019 (Table 1.3). The Vietnamese consistently comprise the largest group of international students, making up about 50% of the total, followed by China (212), Nepal (203), the Philippines (163), and Indonesia (106) in 2019. The number of schools accepting them has expanded from 20 to 167. With the declining number of local enrolees and an increasing number of unfilled slots, taking in international students is important for the survival of the training institutions (Figure 1.1b).

A major concern is the difficulty of passing the 'certified care worker' licensure examination, written in Japanese, which is the prerequisite for working in Japan as long as the care workers want. To qualify, they must either complete a 2-year certified care work course in an accredited care worker training institution in Japan or take on-the-job training in a nursing home for at least 3 years (Figure 1.2). The latter is the common path taken by EPA candidates, technical interns, and specified skilled workers. To give more chances for foreign care workers who are already in the country to take the examination, Japan now allows limited extension of period of stay and switching between schemes (Figure 1.2). For example, under EPAs, they are allowed to extend their stay for another year and later return to Japan to retake the examination. If they fail again, they are allowed to convert their status of residence into SSW(1) even without taking the required SSW skills and language examinations. Likewise, technical interns, at the end of their 5-year term, can now stay in Japan under SSW(1), allowing them more chances to sit for the certification examination. Even if they fail, they can work for another 5 years. The SSW(1) skills and language proficiency evaluation tests can be taken in Japan by tourists or other short-term visitors.

Table 1.3. Number of International Students (New Enrolees) in Certified Care Worker Training Institutions (by nationality, FY2014–FY2020)

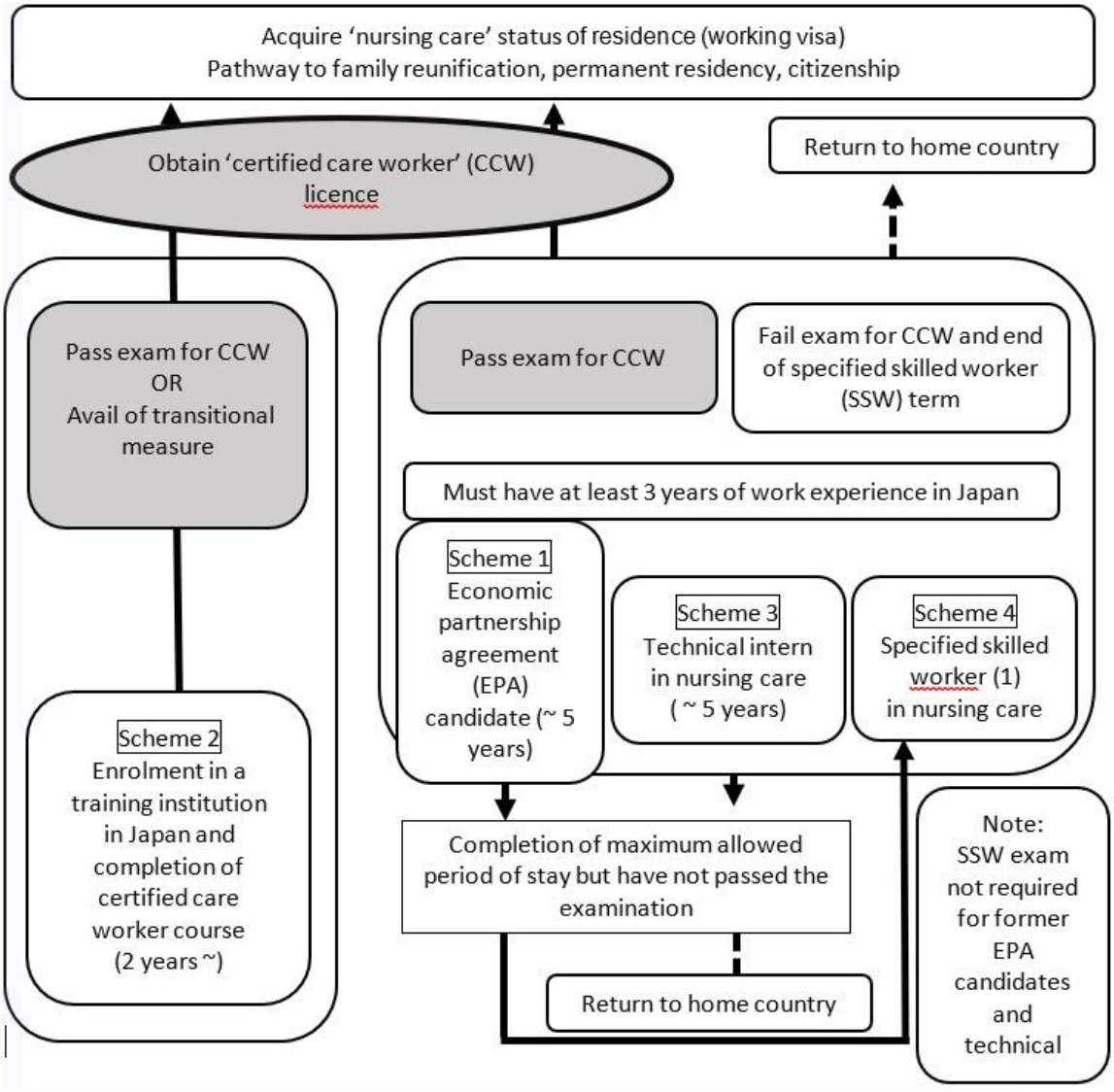
Fiscal Year	2014	2015	2016	2017	2018	2019	2020
Viet Nam	2	39	114	364	542	1,047	1015
China	12	27	53	74	167	212	285
Nepal		15	35	40	95	203	304
Philippines	1		28	35	68	163	274
Republic of Korea		2	3	23	31	28	14
Myanmar		6	5	10	34	99	110
Sri Lanka		1	2	1	47	95	93
Indonesia				4	70	106	153
Others [a]	2	4	17	40	88	84	
Total	**17**	**94**	**257**	**591**	**1,142**	**2,037**	**2,395**
No. of schools where international students are enrolled	N/A	29	49	96	136	167	176
No. of origin countries	5	9	15	16	20	26	20

Note: The fiscal year begins in April and ends in March of the following year. It coincides with the academic year.
[a] Others include India (33), Mongolia (19), and Cambodia (12).
Source: Authors' compilation from Japan Association of Training Institutions for Certified Care Workers (2018 and 2021).

The relaxation of foreign employment policies suggests Japan's desire to expand employment of skilled foreign workers in the long-term care sector in light of strong domestic demand and international labour market competition.

Partly because the TITP and SSW(1) programmes have just started and thus have not been widely implemented, and partly because of the low acceptance and passing rates of workers under EPAs, many Japanese stakeholders consider *kaigoryugaku* as the most viable way to employ skilled long-term care workers in the long run. In the next section, we focus on the advantages and disadvantages of the study scheme, particularly from the perspectives of Japanese stakeholders and Filipino care workers.

Figure 1.2. Acquiring the 'Nursing Care' Status of Residence through the Four Employment Schemes for Foreign Care Workers



Source: Authors' compilation from documents published by the Ministry of Health, Labour and Welfare.

3. Preference for *Kaigoryugaku*

With Japan introducing the four employment schemes simultaneously, which one do stakeholders prefer? For employers, it depends on their need for workers (urgent or future); the size, scope of services, and financial capacity of the company; and on the company's philosophy (*kodawari*) regarding the quality of long-term care services and employment of foreign workers. Foreign care workers' preference depends on varied and complicated factors. During interviews, some factors they mentioned were their intended or planned years of stay in Japan (short or long), attitude towards studying and care work as a profession, desire to bring family members to Japan, and their preference regarding time and monetary investments vis-à-vis the risks in obtaining the certification and timing of economic returns (immediate or long-term). We confine our analysis to the advantages and disadvantages of *kaigoryugaku*. Under what conditions and circumstances is the student pathway chosen (or not)? [12]

Based on observations and on interviews with employers, the study scheme is preferred by those who wish to employ foreign workers trained in 'the Japanese way', thus making them not only 'skilled' but also well 'culturally oriented' and 'competent in the Japanese language' in the long run. Employers may be inclined to utilise the study scheme as it appears to be the 'least risky'. Even if the students fail the certification examination, they can still become certified care workers as part of the transitional measure,[13] or as long as they engage in care work in Japan for 5 years after graduation. Such is not the case for technical interns, EPA candidates, and SSW(1) workers who all need to take and pass the qualifying examination (Figure 1.2). Care work students, however, can work full-time only after 2 years. Therefore, employers see them as a source of skilled workers in the long run rather than as an immediate solution to the labour shortage.

For the foreign worker, the study scheme can be the most expensive pathway in terms of actual and opportunity costs. Unlike EPA candidates, students need to share in the expenses incurred in their training and education in Japan and, in most cases, pay for their recruitment and deployment expenses, as well. Nursing homes and local government units give 'loans' to students, the repayment of which is waived if they work in a nursing home for 3–5 years after graduation. EPA candidates receive a salary, which must be the same as that received by a Japanese full-time worker with the same qualifications, immediately after arrival. Students, however, earn by working part-time (usually with the potential employer) for a maximum of only 28 hours a week. Many of the students interviewed found their first 2 years financially stressful as they needed to draw from their limited income and loaned allowances to pay not only for their daily needs and partial school fees, but also for pre-departure loans and/or remittances. [14]

Despite the monetary costs, foreign care workers still come as students because it is the easiest way. No skill is required upon entry, provided they can prove that they can financially support their education. Even those who cannot speak the language can obtain a student visa to initially study in a

[12] The four schemes were not introduced simultaneously, so it was difficult for care workers and their employers to make an informed decision based on all options when they entered Japan.

[13] The measure stipulates that the certification for care workers is awarded even to graduates of care work training institutions who do not take the examination or to those who took it but failed, as long as they work in the long-term care sector for 5 consecutive years.

[14] Reports show that those who cannot support themselves return home, work illegally (beyond the prescribed 28-hour limit), or quit their studies and find another job in Japan.

language school. It is the least risky because even without passing the certification examination, they can obtain 'nursing care' status of residence if they work for 5 consecutive years after graduation. The strong preference for this status arises from the post-graduation privileges that go with it, such as unlimited stay, family integration (spouse and children), and even the opportunity to acquire permanent residency and eventually Japanese nationality. Being able to learn the Japanese way of long-term care, and being immersed in the Japanese culture, especially pop culture; being in a safe environment; and enjoying the conveniences of living in Japan are some of the attractions. Having learnt long-term care in Japan helps them gain more confidence at work and is advantageous to their career development (interview with a former care work student). The interviewed students did not think of the requirement to work for a specified number of years after graduation as a big burden but as an assurance of immediately landing a job.

However, the study scheme is criticised as a 'bad example' of employing foreign workers because of its lack of provisions to protect the living and labour conditions of students, resulting in cases of exploitation (Asato, 2020). Many students come on a study-now-pay-later programme and pay an exorbitant amount for deployment with loans from study-abroad agents. As a result, students must work beyond the 28 hours allowed by the law. In one celebrated case, a student from the Philippines was enticed to come to Japan on a 'study now, pay later' plan by a study-abroad agent who also runs a Japanese-language school and a nursing care training centre. The agent reportedly loaned the student US$3,000–US$5,000 to pay for pre-departure language training, airfare, visa processing, the language school's initial 3 months of tuition fee, and housing. To pay for the loans on instalment, future school fees, and living expenses, she had to work long hours at the nursing home that would employ her after graduation. The working time exceeding 28 hours per week was considered volunteer work. When she failed to pay the tuition and housing rental fees, her activities were closely monitored by the language school and she was threatened with being reported to the immigration office for deportation (Yahoo News, 2019).

Japanese-language schools cited problems about students coming through the study scheme. Many of these happen during the initial stages of recruitment and deployment and in language schools that lack monitoring systems. In the case of Filipino students, one language school owner complained about being charged excessively by study-abroad agents (about JPY300,000 or US$2,800) as a referral fee.[15] As students, their deployment to Japan is not regulated by the POEA. The study-abroad agents are not subject to the rigid screening by the POEA because they are not labour recruiters. Because of the serious shortage of labour in other sectors, 'head-hunters' entice students to quit school and work as part-time English teachers or in convenience stores (which is most probably illegal as it is difficult to get a working visa for those jobs). Students who wish to earn more tend to miss lectures or sleep during classes because of fatigue after working night shifts.

In the two cases discussed here, it appeared that students were better looked after once they entered the care work training school. Usually, the local government unit, the school, the local care worker professional association, or the future employer offered financial support in the form of scholarship, tuition, housing or transportation subsidy, or loan, on the condition that they worked with the future employer or in the prefecture for a few years (usually 3) after graduation.

[15] In addition to fees collected from the Filipino student.

Based on our interviews, many Japanese stakeholders see the strong potential of *kaigoryugaku* to secure skilled long-term care workers. As a result, local government units have formed alliances with training institutions and future employers and, in some cases, even with the source country government, to promote the study scheme (Carlos and Suzuki, 2020). Care worker training institutions welcome the scheme, not only because international students fill admission slots but also, more importantly, help in campus internationalisation and revitalisation. In some training institutions, new programmes are being developed to attract international students to care work. The scheme's success relies on the extent to which the local government unit and the private sector can collaborate and share the burden of training foreigners as certified care workers.

The dramatic increase in the number of international students of care work, the preference of many future employers and foreign care workers for the study scheme, and the potential of this scheme to supply Japan with skilled and culturally competent care workers explain why it was chosen as the report's main topic. The scheme's implementation, however, is not unproblematic and, in the next section, amongst the various issues we identified from our fieldwork, we focus on issues and concerns in the classroom and after graduation.

4. Issues in the Classroom

Training institutions for certified care workers had been mostly populated by Japanese students (Figures 1.1a and 1.1b). With the dramatic increase in the number of international students since 2014 (see Figure 1.1b) and the general lack of exposure of Japanese students and teachers to multicultural learning and training environments, it is easy to imagine how teachers, students, and school administrators struggle to cope in the classroom. They must deal not with one but several cultures because of the diversity of international students (Table 1.3).

4.1. School Administrative Office and Staff

On the frontline are school administrators and staff who must deal with recruitment, screening, and everyday support of international students. Aside from recruiting students who graduate from Japanese-language schools, training institutions recruit directly from overseas by establishing liaison offices, signing memoranda of agreement with universities and local government units, as well as tying up with study-abroad referral offices or Japanese-language schools in the sending country. In the two case studies, the Filipino students were either recruited from a Japanese-language school in Japan or a study-abroad referral office in the Philippines. Usually, students are interviewed by the staff and/or the future employer to assess their level of Japanese-language proficiency and aptitude for learning the language and care work. Whilst Japanese stakeholders generally prefer nursing graduates, in our two cases, about half of the students were graduates of courses other than nursing.

Helping international students sustain their daily lives and schooling is a major task of school administrators and staff and requires so much of their energy and dedication. The most important of these activities is securing scholarships and/or part-time jobs to support tuition fees and cost of living. The school sometimes acts as guarantor, which is a requirement for a student to rent an apartment or subscribe to a mobile phone. The school liaises between Filipino students and international exchange associations and language support groups to help students adjust to their studies and daily

life. In many cases, schools have strong ties with potential employers that usually provide part-time jobs and practical training. In one case study, the administrators conducted a monthly meeting, sometimes with potential employers, to discuss the progress and concerns of the Filipino students.

4.2. Instructors and Teachers

Instructors and teachers exert much effort to educate the Filipino students. Many revise their teaching styles and are imaginative and creative so that even non-native Japanese speakers can understand the lessons. One instructor interviewed made hand-outs and visual aids with easy-to-understand instructions, focusing on basic technical concepts. Another instructor regularly held group work exercises, which, he said, were useful not only in verifying whether key concepts were understood by all students but also in improving the Japanese-language writing ability of the Filipino students and developing communication skills and personal interactions between the Japanese and Filipino students. The teaching method was effective in keeping students' attention. The instructors were aware that they needed to use simple standard Japanese in lectures. One instructor emphasised that many of his lectures began with introducing terms and *kanji* (Chinese) characters that the Filipino students were not yet familiar with.

Whilst the improvisations in teaching were helpful, they were time-consuming to prepare and execute. An instructor complained that it took three times longer to prepare for a class for Filipino students than for Japanese students. To simplify and make the lessons easily understood by the Filipinos, only key concepts were discussed in class, with the details assigned as homework. Because of the lectures' slow pace, it was difficult to complete discussing all the contents of the syllabus. However, the interviewed instructors thought that teaching international students was 'enjoyable', 'challenging', and could be 'a matter of getting used to it'.

Some interviewed instructors helped the Filipino students cope with daily life. For example, since the school and the dormitory were far from the city and the supermarket, one instructor drove the students once a week to shop for food and supplies. Another mentioned that she and her friends collected appliances and clothes to give to the new arrivals.

4.3. Japanese Classmates

Most of the Japanese students interviewed did not expect to have foreign classmates and were overwhelmed at first. They strongly felt the language barrier as everyone struggled to understand each other. They realised some cultural differences with the Filipinos: for example, the concepts of 'time' and 'family'. One student noted that Filipino students were sometimes late to practical training and classes. Another student appreciated how Filipino students dealt with the elderly, which she thought was because Filipinos respect and highly value them.

In general, the Japanese classmates had a positive attitude towards Filipino students because they were 'inspired' to learn about another country's culture and its people's perceptions about long-term care, which, in turn, made them know and appreciate their own Japanese culture. They 'could not imagine' themselves as international students and admired the Filipino students' tenacity.

In the classroom, however, Japanese students were anxious about learning side by side with Filipino students. They thought the lectures were slow-paced and simplified, so they had to study by themselves the topics not covered. They worried that they would fail the certification examination. Nevertheless, the Japanese students were supportive of the Filipino students. They acted as 'tutors' in class, correcting the Filipino student's Japanese and discussing Japanese culture. In practical training, in which all students were assigned to work for a few days in a nursing home or facility, one Japanese student who owned a car picked up the Filipino student to go to the site together. Another Japanese student mentioned that sometimes he acted as 'interpreter' between the Filipino student and the nursing home staff.

From the interviews, it could be sensed that the Japanese students had some issues about having foreigners as co-workers in the future. First, considering the difficulty of learning Japanese and the different cultural backgrounds, the Japanese students had doubts about the care of Japanese elderly being entrusted to foreigners. Second, the Japanese students were worried they would need to look after the foreign co-workers, which could add to the burden of a busy schedule and shortage of labour. Third, they felt that they may need to take up some of the responsibilities of foreign workers because of their limited language proficiency: for example, writing residents' reports accurately. Learning side by side with international students is a good opportunity for Japanese students to assess what roles they can take in the future as a member and/or leader of a multicultural workforce.

4.4. Filipino Students

The eight Filipino students in the two case studies struggled with daily life and studies in Japan. However, they felt lucky that they were better looked after than other Filipino care work students. Their topmost concern was how to catch up with their studies given their limited Japanese-language ability. They found writing reports in class and during practical training and memorising terms and concepts in Japanese extremely difficult. Several said they spent about 3 hours a day reviewing and preparing for their lessons, and another hour or 2 reviewing for the Japanese-language proficiency examination. Sometimes they felt frustrated when they could not communicate well with their teachers and classmates.

Understanding cultural differences was a major concern for the Filipino students. They thought the Japanese students had some reservations in dealing with foreigners, and it would take some time to adjust to each other's personalities. During practical training, they were cautious about observing the Japanese way of doing things. For example, bath water temperature should be controlled depending on the preference of the elderly, which is usually high for Filipinos. Another concern was dealing with the elderly with dementia, which is not a commonly diagnosed disease in the Philippines.

The Filipino students hoped that some of the physical inconveniences, especially during winter, could be reduced. The school campus was far from the city, and it was difficult to commute using the limited public transport. In some cases, the nursing homes where they were undertaking practical training and the supermarket were inaccessible from the school and dormitory. The problem was experienced by many foreign care workers working in remote areas; Tanaka (2020) called them *kaimono nanmin* (shopping refugees). Finally, the Filipino students were worried about their finances and wanted to have more time to work part-time.

4.5. Association of Training Institutions for Certified Care Workers

The association has been at the forefront of identifying and understanding the issues surrounding the *kaigoryugaku* scheme. The association has comprehensively surveyed school administrators, teachers, and international students.[16] It launched a consultation centre for international students of care work and published a handbook and guidelines for Japanese workers in nursing homes that employ foreign workers. It is active in policy recommendation, such as urging the government to extend the transitional measure beyond March 2022. In the absence of a national agency managing the education of foreign care workers, the association is expected to assume more roles in monitoring and providing feedback about the scheme.

Evidently, there is an urgent need to assist stakeholders in addressing the emerging issues and concerns in training institutions. Similar concerns were identified at the beginning of the EPA scheme, between foreign and local staff, and most were resolved through time and huge efforts by foreign workers and those working with them. The Japan International Corporation of Welfare Services (JICWELS) played a significant role in liaising amongst the stakeholders in Japan and the Philippines and between public and private sectors. The establishment of a similar organisation is crucial to help solve these issues and concerns mentioned above and sustain the study scheme.

5. Emerging Post-graduation Issues

5.1. Low Passing Rate in Certification Examination

The Japanese stakeholders are concerned that the certification examination is too difficult for international students and will considerably limit the number of graduates who can renew their status of residence as kaigo. Table 1.4 shows how international students perform compared to their Japanese counterparts. Of the graduates who took the March 2019 examination, 86.5% passed. The Japanese who had previous experience in care work and took the refresher course (returnees) registered the highest passing rate, 98.2%, followed by the Japanese fresh graduates at 88.6%. The passing rate of international students was a mere 26.8%.

Table 1.4. Performance of Graduates of Care Worker Training Institutions in the National Licensure Examination for Certified Care Workers (FY2019)

As of end of March 2019	No. of Graduates	No. of Exam Takers	No. of Exam Passers	Passing Rate (as % of total takers)
No. of graduates	6,028	5,698	4,928	86.50%
of which				
(a) returnees to the profession who took up the course (Japanese)	1,076	1061	1,042	98.2%
(b) international students	391	362	97	26.8%

[16] For details, refer to the website of the Japan Association of Training Institutions for Certified Care Workers (in Japanese). See the survey results here (2019a) and the handbook (n.d.).

(c) others (except a and b)	4,561	4275	3,789	88.6%

Note: The data include graduates of 366 member institutions (99% of total number of members) of the Japan Association of Training Institutions for Certified Care Workers.
Source: Japan Association of Training Institutions for Certified Care Workers (2019b).

The significant gap in the passing rates between the Japanese and the international students (graduates) is largely attributed to the latter's lack of Japanese-language proficiency. To alleviate this problem, international examinees can select between two test booklets: one in which furigana (phonetic characters) are placed above all kanji, and one in which furigana are written only above rare or difficult-to-read kanji. To raise the passing rate, the Japan Association of Training Institutions for Certified Care Workers is requesting the government to extend the examination period to 1.5 times longer than the current time allowed. 17 Under the transitional measure set by the Japanese government, those who graduate from training institutions until March 2027 can be issued a 'care worker' status of residence (working visa) even if they did not take or they failed the certification examination. In such cases, they can obtain the certification if they are employed in care work for 5 years.

5.2. Direct-hire Ban in the Philippines

Meeting the Philippines' overseas deployment rules and regulations is a major concern for employers and students. When Filipinos are deployed to Japan as EPA candidates, technical interns, or SSW(1) workers, they must undergo the standard pre-departure procedure with the POEA, which includes the intervention of a recruitment agency or similar organisation.[18] However, students are not required to do so and are classified as 'direct hires'. Employment through direct hire (without going through a POEA-licensed recruitment agency) is prohibited in the Philippines, as stipulated in the 1974 Labor Law Article 18: 'No (foreign) employer can hire a Filipino worker for employment except through the Boards and entities authorised by the Secretary of Labor.'

The law was passed when human and labour rights abuses against Filipino domestic workers in the Middle East were rampant and when access to information about labour market conditions and employment practices in the destinations was limited. Then, deploying overseas Filipino workers (OFWs) through POEA-accredited recruitment agencies was a way to protect them. However, as occupations, destinations, and type of employers for OFWs diversify, and as access to information becomes easy and immediate, the POEA realised the need to review its direct-hire ban policies. In 2016, it established guidelines for exemptions from the ban. Today, professional and skilled workers, including former students, can be exempted provided they and their employers comply with the following conditions:

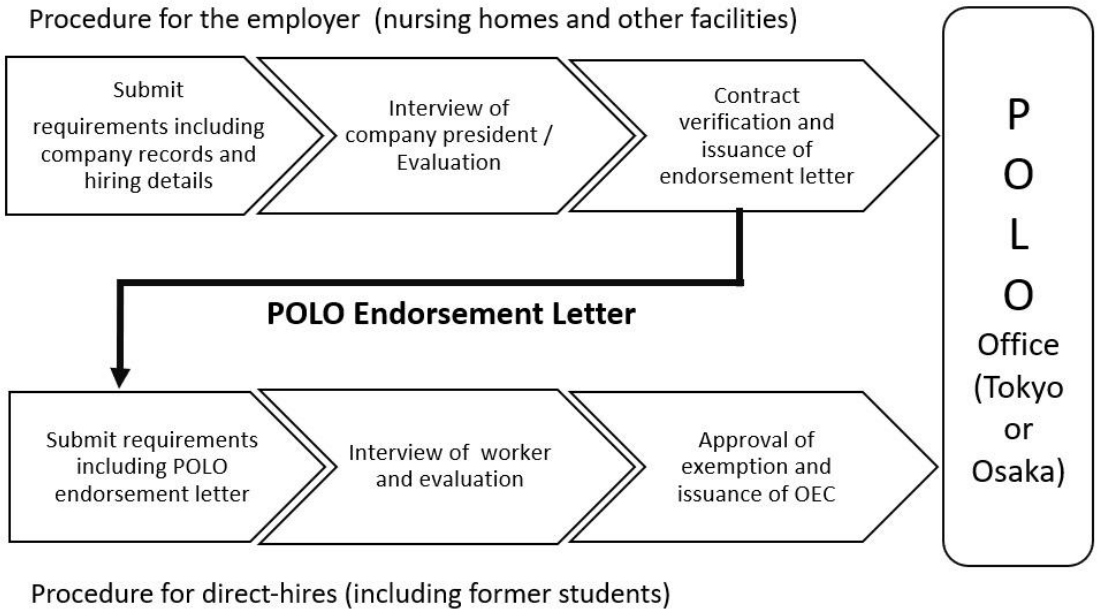
Professionals and skilled workers with **duly executed/authenticated contracts containing terms and conditions over and above the standards set by the POEA; and** the number of professional and skilled Overseas Filipino Workers hired for the first time by the employer shall **not exceed five (5)**. To

[17] Currently, the time extension is permitted only for EPA candidates.
[18] The recruitment and deployment of EPA candidates are facilitated by the POEA. Technical interns and SSW(1) workers must go through a sending organisation or dispatch and/or accepting organisation, respectively. The organisations must be accredited by the POEA.

determine the number, workers hired as a group shall be counted as one. (Revised POEA Rules and Regulations Governing the Recruitment and Employment of Land-based Overseas Workers of 2016, Section 124 d.2. in POEA, n.d.)[19]

An employer who intends to directly hire a care worker must have the employment contract verified at the Philippine Overseas Labor Office (POLO) and obtain a POLO endorsement letter, which, in turn, should be presented by the Filipino employee to register as an OFW and be issued an overseas employment certificate (OEC) (Figure 1.3) (POLO Tokyo, 2018b).

Figure 1.3. Procedure for the Exemption from the Direct-hire Ban and Application for the Overseas Employment Certificate (as of March 2019)



POLO = Philippine Overseas Labour Office, OEC = Overseas Employment Certificate.
Source: Authors' illustration based on Philippine Overseas Labour Office (POLO) Tokyo (n.d.).

Training-school administrators and future employers think the procedure is complicated, tedious, and not transparent (see Figure 1.3). First, they need to submit an employment contract that contains terms and conditions 'over and above the standards set by POEA', but this is difficult to determine. Many of the standards are uniform amongst occupations and are not always publicly announced, such as the standard on salaries. Second, some documents are not commonly issued in Japanese companies. For example, instead of a personal employment contract, a general employment contract covering **all** employees and indicating a general job description is published as an employment regulation manual (*shugyokisoku*). Nursing homes, many of which are small, may not have the in-house resources to draft and translate the documents into English. Third, many employers, especially big companies, find it difficult to comply with the requirement of the company president's personal appearance for an interview with the POLO officer. Finally, even if exempted from the ban, the employer can hire only

[19] The same provision can also be found in POEA's Memorandum Circular 08 Series of 2018 (POLO Tokyo, 2018b).

up to five workers. Above this number, the company must go through a recruitment agency in the Philippines. Whilst employers and contracts must be screened to ensure that the rights of OFWs are protected in Japan, Filipino graduates could be put at a disadvantage as potential employers turn to workers from other sending countries where deployment rules are less stringent, such as Indonesia and Viet Nam.

The Filipino graduates expressed apprehension regarding the direct-hire ban because they need to complete the procedure with POLO and obtain the OEC as a *balik manggagawa* (returning worker) before taking a vacation in the Philippines. Failure to present the OEC to the Philippines immigration officer at the port of exit would delay or even prevent their return to Japan.

The direct-hire ban exemption is a concern not only of care work graduates but also of other skilled workers in other occupations and in other countries. The POEA is aware of the problem and has organised a research project, Direct Hiring of Overseas Filipino Workers—Policy Research and Development of Risk Assessment and Due Diligence Guidelines, together with the International Organization for Migration, the Department of Labor and Employment, and the Scalabrini Migration Center to review the ban and explore ways of implementing it within the context of contemporary labour migration, globalisation, and technological developments (Scalabrini Migration Center, 2021).

6. Summary of Findings and Policy Suggestions

Our key findings are as follows:

(i) The study scheme *(kaigoryugaku*) is a viable way to employ skilled care workers (certified care workers or *kaigofukushishi*) in the long term because (a) foreign workers learn Japanese skills in long-term care and develop cultural competency (including language proficiency) through formal education in training institutions in Japan, and (b) it is the **only** pathway where passing the national examination is not required to obtain certification and the 'nursing care' status of residence.

(ii) Implementing the study scheme has not been easy, and shortcomings and emerging concerns need to be immediately addressed. We identified two sets of stumbling blocks, the first of which refers to problems in the formal education of Filipino and other international care work students in training institutions. The **sudden** increase in their number and the lack of experience of Japanese stakeholders in dealing with them have created confusion in the classroom and campus.

(iii) The second concern refers to issues after the international students complete their studies. We identify their poor performance in the certification examination and, in the case of Filipinos, the rules and regulations of the sending country (specifically the direct-hire ban). Poor performance in the certification examination has not been a problem yet because of the transition measure. The direct-hire ban, however, is expected to limit the number of students from the Philippines because of the complicated procedure required of employers in hiring graduates.

As in any new policy or scheme, these problems and issues may be birth pains. Nevertheless, policy interventions and revisions are necessary, as we suggest below.

To address the issues in the classroom and campus, programmes to enhance the Japanese-language proficiency of international students are urgently needed. There are many ways to this end, but the costs (actual and opportunity) and availability of resources are barriers to carrying them out. Standard language proficiency to enter training institutions can be more strictly enforced but requires more intensive, more efficient, and longer language study.[20] The Japanese-language school and the training school can collaborate to ensure that international students learn technical terms. International students in training institutions should continue learning Japanese, including the local dialect, such as those in the two case studies.

Improving international students' Japanese-language proficiency will help improve their passing rate in the certification examination. Lessons can be learnt from the EPA experience, such as the conduct of intensive review classes to familiarise students with the questions and style in which they are constructed. As strongly suggested by the Association of Training Institutions for Certified Care Workers, the time to complete the exam can be extended. Whilst the transitional measure is still in effect and international students are exempted from taking the examination, the government and the long-term care sector must design alternative ways to measure and maintain a standard of quality of their care work skills.

To oversee the study scheme and assist administrators and teachers in addressing the concerns of international students, a nationwide government support organisation or agency, similar to JICWELS, must be established (Table 1.1). It may take various roles, including regulating and monitoring the scheme and providing language courses, examination reviews, and consultations on work and life in Japan. The agency can initiate talks and coordinate with the government of sending countries to facilitate the smooth implementation of the scheme. It will help teachers develop materials and techniques in teaching long-term care and act as a coordinator to facilitate exchange and share information and ideas, particularly good practice in teaching, amongst educators. The agency can provide support and advice to companies planning to get an exemption from the direct-hire ban, especially small or medium-sized nursing homes that have difficulty accomplishing the English-language requirements. The agency can assume the role of liaison amongst the private stakeholders in the source country and in Japan to promote mutually beneficial and sustainable student scholarship and support programmes (Carlos and Suzuki, 2020).

Whilst it is difficult to repeal the law on the direct-hire ban, ways to make its implementation more feasible and in tune with the current times without sacrificing the rights and welfare of OFWs must be explored.[21] For example, the procedure can be streamlined considering the laws, common standards, and cultural practices in the host country. Intensive review of government rules and regulations and records related to personnel management and labour relations in the sectors where the OFWs are employed can help assess whether their rights are protected. In the case of Japan, authorities can consider accepting the general employment contract (*shugyokisoku*) instead of the private employment contract and may require supplemental documents for items that are usually not found there, such as the 'repatriation' clause. Instead of a blanket list of requirements covering all OFWs,

[20] Students with only an N3 level are allowed to enter as long as they enrolled in a Japanese-language school for at least 9 months.

[21] During fieldwork in the Philippines, it was learnt that the government was reviewing the direct-hire ban and thinking of ways for the law to be more reflective of and applicable to the current international labour market conditions.

the contract can be tailored based on the destination, occupation, or even regions or areas within one destination. Rather than a general minimum salary standard for all sectors and areas in Japan, the POEA can consider referring to sector and area rates, which are announced publicly and regularly. If a personal interview with the company president is difficult, alternative objective ways to assess the credibility of the employer can be explored, such as checking the size of the company and records or other resources that can be provided by Japan's Labour Standards Bureau.

The Labour Bureau (*Rodokyoku*), under MHLW, strictly implements measures to secure and improve working conditions, ensure the safety and health of workers, guarantee the provision of workers' compensation, and promote workers' living standards. The bureau can conduct an onsite visit to a company to verify and resolve workers' complaints. It is mandated to reprimand and penalise employers that violate labour laws. It keeps records and periodically publishes on its website the details of worker violations by corporations. The MHLW's website is a wealthy source of updated information (with some translated into English) regarding labour standards, conditions, and issues in the country that the government of the Philippines can refer to.[22]

In summary, whilst the study scheme has strong potential to fill the need for skilled care workers in Japan, many areas still need to be improved. The measures are costly and require energy and commitment from stakeholders. With the proliferation of unverified information on the internet, ease of international travel, and growing number of stakeholders with divergent interests, achieving a stable supply of much-needed skilled care workers whilst securing the rights of foreign workers has become more and more challenging.

7. Policy Implications of the Care Worker Foreign Labour Schemes in Japan

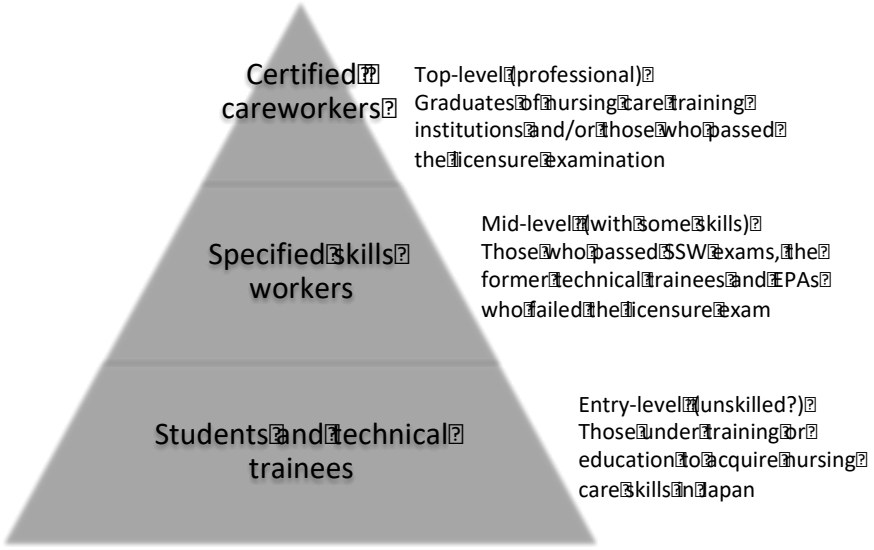
Our research findings suggest two macro-level policy implications in the labour market for foreign care workers. First, the simultaneous implementation of the four schemes promotes a hierarchy in the labour structure of foreign care workers in Japan (Figure 1.4).[23] Under the current schemes, foreign care workers are highly stratified based on their skills and language ability, which are screened through the certification examination and language proficiency tests. The elite group comprises those who obtained the certification and, as certified care workers, have 'nursing care' status of residence. As full-time employees, they are entitled to a monthly certification allowance, bonuses, and other monetary benefits and career opportunities to be head of a ward or trainer of other Filipino care workers. They have immigration privileges such as being able to petition their family to come to Japan, unlimited renewal of period of stay, and even a chance to receive permanent residency and citizenship. Those who graduated from a Japanese training school will belong to this group as long as they engage in care work for 5 years after graduation. Other care workers in the group will comprise foreign care workers who took and passed the certification examination under the three other schemes.

[22] For example, MHLW and the prefectural bureaus published a pamphlet about labour laws, standards, and issues—'Are your Working Conditions Fair? For Foreign Workers in Japan'—on the MHLW website in English, Spanish, Portuguese, Chinese, Korean, Tagalog, and Japanese.

[23] In Japan, labour stratification has so far not been a major issue in the discussion about employment of foreign care workers. The pros and cons of the structural/hierarchical model would be interesting to tackle in future studies.

The hierarchical arrangement is a practical and cost-effective way to secure a foreign workforce tailored to Japan's multi-level skills and language needs. Whilst certified care workers play an important role in the nursing homes, their number is small because training and hiring them is expensive and time-consuming. SSW(1) and EPA candidates at the middle of the hierarchy, and care work students and technical interns at the bottom can meet the immediate needs of nursing homes, where less skill-intensive tasks, such as preparing tea, folding laundry clothes, keeping the elderly company, etc., that comprise a considerable part of caregiving, can be performed by those who are not certified.[24] Except for *kaigoryugakusei*, foreign care workers can move up in the hierarchy only by passing skills and language examinations. Switching between schemes is allowed for SSWs, technical interns, and EPA candidates to provide more opportunities to take and pass the certification examination.

Figure 1.4. Potential Hierarchy of Foreign Care Workers in Japan



EPA = Economic Partnership Agreement, SSW = Specified skill worker.
Source: Authors.

Another implication that must be considered by policymakers is the feasibility and viability of joint management of labour migration. Rather than the host country or the sending country facing the challenges separately, both countries should conduct dialogues and consultations with each other to explore areas of collaboration and jointly manage labour migration. Host countries have traditionally controlled labour migration by imposing restrictive policies for foreign workers. However, because of increasing international demand for workers and growing concern for their human and labour rights, sending countries have begun to implement stricter deployment regulations, such as the direct-hire ban and close monitoring of the deployment process, as in the case of the Philippines. Whilst the

[24] Further studies are needed to determine whether employing care workers as technical interns and SSW(1) workers is cheaper than as EPAs or former students. Some employers claim that whilst these workers' salaries are lower and benefits fewer, recruitment fees and monthly contributions to the sending or support organisation add significantly to the cost of employing foreign workers.

sending government has good intentions, such measures can sometimes be to the detriment not only of workers but also of stakeholders in the host country, who struggle to comply with the regulations and bureaucratic procedures. Workers and employers may be induced to explore ways to circumvent them and, as a result, may have a negative impact on the welfare of the workers whom the sending country is trying to protect.[25]

A new paradigm of joint management by the sending and receiving countries is necessary for the success of any scheme for foreign labour migration. The government-to-government EPA scheme is an example of joint management, but its impact on the labour market is small because of the limited fiscal and human resources that can be dedicated to the programme. In this new paradigm, ways in which the private sector in the sending and host countries can be more active and effective, not only in the employment but also in other different stages of labour migration, such as recruitment, deployment, and training, must be explored. However, its success depends on the willingness of the two countries' governments to negotiate. This, in turn, depends on domestic demographic, economic and political conditions (for example, Japan's demand for care workers and the Philippines' unemployment situation) and their global context (increasing international competition for care workers amongst destinations). Success depends, most importantly, on how much the governments and the private sectors trust each other.

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Chapter 2

Factors Influencing Migration and Job Satisfaction amongst Malaysian Nurses Working in Other Countries

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The shortage of nurses is a global issue that impacts healthcare settings worldwide. The World Health Organization reported an incredible dearth of nurses globally. Many countries have developed strategies, including recruiting foreign nurses, to counteract the 'crisis in the nursing workforce', which increases the number of nurses migrating to other countries. Malaysian nurses are being recruited to work in the Middle East, Singapore, and Australia. A clear understanding of nurses' job satisfaction is crucial to improve nursing practice in different healthcare systems and cultures.The study assesses the factors influencing migration and job satisfaction amongst Malaysian nurses working in other countries.A cross-sectional online survey was conducted amongst Malaysian nurses working abroad. Frequency, percentage, mean, and standard deviation were used for descriptive data. Student t-test and analysis of variant (ANOVA) were used for the inferential statistics.A total of 165 participants (77.5%) are satisfied working in other countries. The total mean satisfaction score is 28.00±SD6.03. There is no significant association between the nurses' total satisfaction score and sociodemographic characteristics except for first nursing education and job satisfaction level of Malaysian nurses working in other countries, with a P-value of ≤ 0.05. The total challenging experience total means score is 29.68±SD8.33. There is a significant association in the five components of the challenges encountered by nurses with nurse demographic characteristics such as first nursing qualification, highest academic degree, experience in nursing, length of time working abroad, and type of workplace, with a P-value of ≤ 0.05. The study outlines job satisfaction and the reason for Malaysian nurses working abroad. Overall, they are satisfied and choose to work abroad mainly because of high salaries and good benefits. The work challenges in Malaysia can be a factor pushing nurses to work in other countries.

1. Introduction

Nursing service is essential. A shortage of nurses affects the effectiveness of quality care provision (Rajan, Oda, and Tsujita, 2017). The scarcity of nurses has been an issue worldwide (Matsuno, 2009). A previous study found that developed countries such as the United States and the United Kingdom projected a 29% shortage of registered nurses by 2020 (Matsuno, 2009).

Demand for nurses impacts healthcare settings worldwide. The World Health Organization (WHO) reported that Asia has a great dearth of nurses, especially in countries with large populations such as Bangladesh, India, and Indonesia. As of 2011, Thailand was facing a shortage of 43,000 nurses in the public and private sectors, and community, general, and specialist service hospitals claimed a shortage of 18,230 registered nurses (National Health Commission Office of Thailand, 2011). Singapore reported that a deficiency of nurses continued to be a serious concern (Matsuno, 2009). Singapore should have had almost 50,000 nurses by 2020 but only 36,000 nurses were working in 2018 in private and public hospitals (Health Information and Management System Society Asia Pacific, 2018).

As of 2017, there was 1 nurse for every 300 people in Malaysia, far from the WHO recommendation of 1 to 200; to achieve the ratio, Malaysia would need 130,000 nurses, up from the current 105,988 registered workforce (Malaysian Nursing Board, 2017). Of the total population as of 2018, 6.5% (2.10 million) were senior citizens (65 years and above) (Department of Statistics Malaysia, 2018). The senior population is expected to increase by 2030 (Barnett, Namasivayam, and Narudin, 2010).

To counteract the 'crisis in nursing workforce', many countries have developed strategies, including recruitment of foreign nurses. Malaysia has signed agreements with Albania, Bangladesh, India, Indonesia, Myanmar, Pakistan, and the Philippines for their nurses to obtain a temporary practicing certificate to work in Malaysia and is employing them to bolster the workforce. Malaysian nurses, however, are being recruited to work abroad such as in the Middle East, Singapore, and Australia. According to the health ministry, 3,000 Malaysian nurses are working in the Gulf countries (Augustin, 2017). A total of 12,458 nurses are registered with the Oman Nursing and Midwifery Council (Shukri, 2020), 63% (5,109) of whom are Omani and 37% from 40 countries, mainly India (6,056), the Philippines (523), Malaysia (146, 1.2%), and others.

Despite the constantly high demand for nurses over the decades, data are limited to gauge Malaysian nurses' migration to other countries. Therefore, it is crucial to evaluate the purposes of migration and resolve the issues and challenges of working in Malaysia and abroad.

General Objective

The objective of the study was to assess the factors influencing migration and job satisfaction amongst Malaysian nurses working in other countries.

Specific Objectives

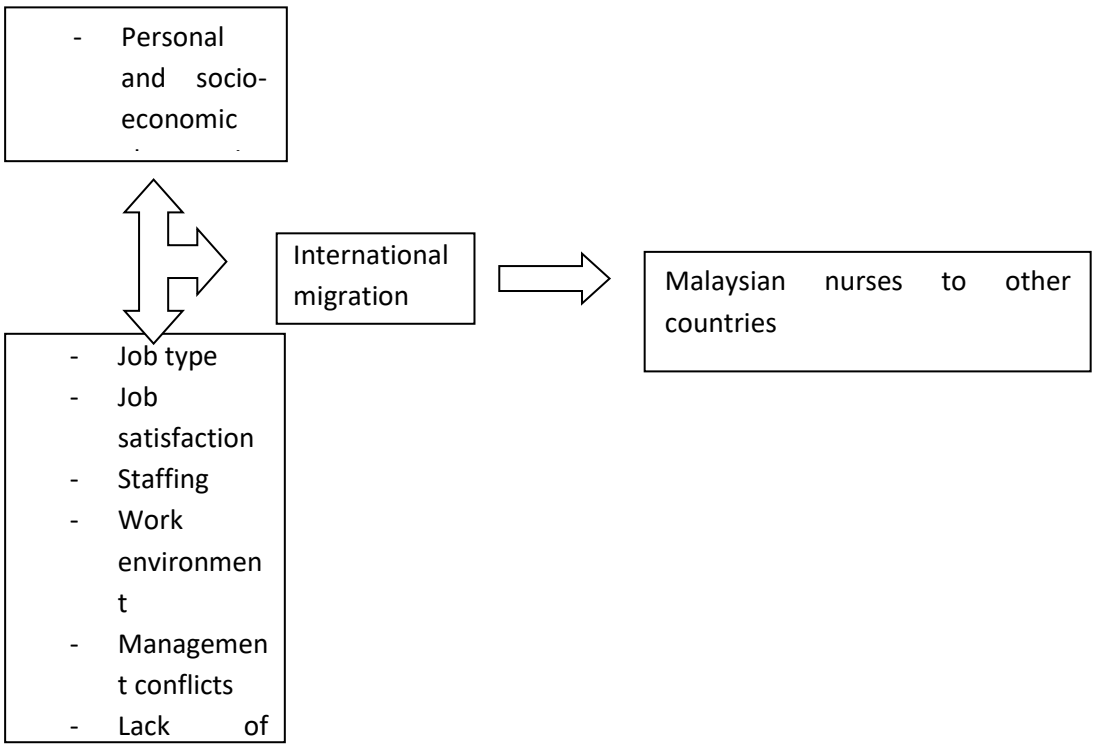
(i) Determine the factors affecting Malaysian nurses' migration to other countries.Elucidate the job satisfaction level of Malaysian nurses working in other countries.

(ii) Examine the association between job satisfaction level of Malaysian nurses working in other countries and their characteristics.
(iii) Explicate the association between the challenges of working in Malaysia and the characteristics of nurses working in other countries.

Conceptual Framework

Figure 2.1 illustrates the migration of Malaysian nurses. Personal and socio-economic status is one reason they migrate. Other factors are a better working environment abroad, more opportunities for career development, greater occupational advancement, and higher economic status. The push factors in Malaysia, such as lower wages, poor working conditions, inadequate support, and conflicts with management, have led to demoralisation and burnout. The intensity of workload and poor working conditions drive nurses to migrate, retire early, or even leave the profession.

Figure 2.1: Conceptual Framework of Migration of Malaysian Nurses



2. Methods

Research Design

The Nurse Migration Survey was a study designed as quantitative research using an online survey. The quantitative analysis describes international migration and job satisfaction levels amongst Malaysian nurses working in other countries.

Instrument

The study was used to describe the socio-economic background of Malaysian nurses working in other countries, job satisfaction level, and the difficulties of working in Malaysia. The survey included personal profiles, educational details, career advancement working abroad, and reasons of leaving Malaysia.

Participants

This study was conducted amongst 200 Malaysian nurses working as registered nurses in other countries. Bibi Florina, the former director of nursing, said about 3,000 nurses were working abroad (Augustin, 2017). The study's sample size was 213. The inclusion and exclusion criteria of the participants were as follows:

Inclusion Criteria

Malaysian nurses working in other countries

Currently working as a registered nurse, nurse assistant, or caregiver in other countries

Exclusion Criteria

Non-Malaysian nurses

Holding a nurse aid or nurse assistant license or any related degree

Data Collection

The nurses were identified through alumni nurses, email, phone, mail, social media, video conferencing, or nurses working in other countries. Nurse agents were contacted to help distribute questionnaires. The Nurse Migration Survey, consent form, and participant information sheet were emailed when the nurses' email addresses were identified. As there was no list of a target population, a snowball sampling technique was used to select Malaysian nurses who met the study criteria of the sample population.

Data Analysis

Data were analysed using Statistical Package for the Social Sciences version 24. Descriptive statistics were used to describe the personal and socio-economic backgrounds of Malaysian nurses. The quantitative analysis consisted of two stages: (i) descriptive statistics and analysis (frequency, percentage, mean, standard deviation); and (ii) differences between variables with student t-test and ANOVA to determine the association between job satisfaction level and challenges faced by Malaysian nurses working abroad and nurse demographic characteristics. The significance level was determined at a p-value of ≤ 0.05.

Ethical Considerations

The ethical approval to conduct the study was obtained from the Universiti Putra Malaysia Ethics Committee for Research Involving Human Subjects. The participants were required to answer a self-administered questionnaire. The return of the completed questionnaire indicated that they had consented to the study. All participants' information was handled confidentially according to applicable laws and regulations. When the study results are published or presented, participants' identities will not be revealed. Data were archived and may be transmitted abroad for analysis, but participants' identities will not be revealed at any time.

3. Results

Response Rate

A total of 223 participants responded to the questionnaire; 2 were excluded as they no longer worked abroad. After data cleaning, another eight were excluded as they had just completed their nursing studies in the last 3 years. The final number of participants was 213 or a response rate of 95.5%.

Sociodemographic Characteristics

Participants who were 31–40 years old made up 48.8% (n=104) and those 21–30 years old 23.9% (n=51). The mean age and standard deviation (SD) were 36.7±7.4 years old. Most participants were female (94.8%, n=202) and Muslim (67.6%, n=144); 51.6% were married and 39.0% single. Most did not have relatives working as nurses (54.0%, n=115) or relatives who worked abroad (74.2%, n=158). Most responders had never emigrated before (86.9%, n=185) but had contacts in the current country of destination (70.0%, n=149). About 44.1% (n=94) of the participants had worked abroad for more than 4 years. Table 2.1 shows participants' social demographics.

About 59.2% (n=126) of the participants had more than 10 years of working experience, with a mean and SD of 12.8±7.8; 72.3% (n=154) had graduated with a diploma in nursing and only 22.5% (n=48) had a bachelor's degree in nursing. More than half the participants obtained their highest educational qualification from private universities (54.9%, n=117), mainly in Malaysia (94.4%, n=201).

Almost all nurses involved in the study were registered with the Malaysian Nursing Board (98.1%, n=209). Most were working in Saudi Arabia (79.3%, n=169), most were registered nurses (90.1%, n=192), and most were working in the government sector (74.2.%, n=158) and in hospitals (99.1%, n=211). Most participants declared that they themselves (55.9%) or a parent (39.4%) were the most important motivator for choosing nursing.

Table 2.1: Sociodemographic Characteristics and Nursing Background of Migrated Malaysian Nurses

Demographic (n=213)	n(%)	Mean±SD
Age		36.7±7.4
21–30	51(23.9)	
31–40	104(48.8)	
41–50	46(21.6)	
≥51	12(5.6)	
Gender		
Male	11(5.2)	
Female	202(94.8)	
Religion		
Hindu	17(8.0)	
Christian	34(16.0)	
Muslim	144(67.6)	
Buddhist	15(7.0)	
Sikh	3(1.4)	
Current marital status		
Single	83(39.0)	
Married	110(51.6)	
Widowed/Separated/Divorced	20(9.4)	
Is there any nurse amongst your family/relatives?		
Yes	98(46.0)	
No	115(54.0)	
Has any nurse amongst your family/relatives worked abroad as a nurse?		
Yes	55(25.8)	
No	158(74.2)	
Have you previously emigrated?		
Yes	28(13.1)	
No	185(86.9)	

Do you have family, friends, professional colleagues, and other contacts in the current country of destination?		
Yes	149(70.0)	
No	64(30.0)	
How long have you been working abroad? (years)		54.1± 49.2
≤1	56(26.3)	
>1–3	49(23.0)	
>3–5	16(7.5)	
>5	68(31.9)	
Experience in nursing (years)		12.8 ± 7.8
≥ 5	39(18.3)	
6–10	62(29.1.)	
11–15	51(23.9)	
≥ 16	61(28.6)	
First nursing qualification		
Certificate in nursing	11(5.2)	
Diploma in nursing	154(72.3)	
Bachelor's degree in nursing	48(22.5)	
Where above qualification/degree was acquired		
Malaysia	210(98.6)	
Singapore	1(0.5)	
Saudi Arabia	1(0.5)	
United States of America	1(0.5)	
Type of above nursing school/college		
Government	110(51.6)	
Private	103(48.4)	
What is your highest academic degree?		
Postgraduate	18(8.5)	
Bachelor's degree	97(45.5)	
Post-basic or bachelor of science	48(22.5)	
Diploma/General	50(23.5)	
Type of above nursing school/university		
Government	96(45.1)	
Private	117(54.9)	
Where highest academic degree was obtained		

Malaysia	201(94.4)
Saudi Arabia	2(0.9)
Singapore	2(0.9)
United Kingdom	4(1.9)
Australia	2(0.9)
United States of America	2(0.9)
Current registration status with Malaysia Nursing Board	
Not registered	4(1.9)
Registered	209(98.1)
Where are you currently working?	
Saudi Arabia	169(79.3)
Singapore	16(7.5)
United Arab Emirates	8(3.8)
Oman	7(3.3)
Germany	6(2.8)
Bahrain	5(2.3)
Australia	1(0.5)
United Kingdom	1(0.5)
Current occupation in other countries	
Registered nurse	192(90.1)
Midwifery staff	13(6.1)
Nursing administrator	4(1.9)
Nurse educator	3(1.4)
Director of nursing	1(0.5)
Current workplace	
Hospital	211(99.1)
Others	2(0.9)
Type of workplace	
Government	158(74.2)
Semi-government	33(15.5)
Private	22(10.3)
Who decided/motivated/persuaded you to study nursing?	
Yourself	110(51.6)
Father/Mother/Parents	83(39.0)

Others	20(9.4)
Most important out of the above	
Yourself	119(55.9)
Father/Mother/Parents	84(39.4)
Others	10(4.7)

4. Factors Driving Malaysian Nurses to Migrate to Other Countries

Reasons for Working in Other Countries

The primary motivation for working in other countries is higher salary and better benefits (96.7%, n=206). They were also cited as the most important reason (82.6%, n=176) for working abroad. Developing a high level of nursing skills (36.6%) and achieving a better quality of life (31.9%) were amongst the factors that inspired them to migrate. Table 2.2 details the reasons for working in other countries.

Table 2.2: Reasons for Working in Other Countries

Reasons	Yes n(%)	No n(%)	Most important n(%)	Second most important n(%)
Higher salary and better benefits	206(96.7)	7(3.3)	176(82.6)	33(15.5)
Higher level of nursing skills and technology	78(36.6)	135(63.4)	52(24.4)	50(23.5)
Better quality of day-to-day life	68(31.9)	145(68.1)	39(18.3)	43(20.2)
Same religion	41(19.2)	172(80.8)	30(14.1)	42(19.7)
Self-respect/dignity	31(14.6)	182(85.4)	30(14.1)	33(15.5)
Children's education/future	24(11.3)	189(88.7)	30(14.1)	40(18.8)
Interested in country's culture	16(7.5)	197(92.5)	14(6.6)	43(20.2)
Can speak the local language	15(7.0)	198(93.0)	12(5.6)	39(18.3)
Can bring/petition family	11(5.2)	202(94.8)	18(8.5)	34(16.0)
Family/relatives live there	10(4.7)	203(95.3)	17(8.0)	40(18.8)
Possible to obtain the country's nursing license	9(4.2)	204(95.8)	15(7.0)	32(15.0)
Geographical proximity (near Malaysia)	6(2.8)	207(97.2)	8(3.8)	43(20.2)
Low recruitment and processing fee	6(2.8)	207(97.2)	11(5.2)	37(17.4)
Can obtain citizenship	3(1.4)	210(98.6)	12(5.6)	37(17.4)

Reason for Studying Nursing

The study aimed to find the main reason for studying nursing. Easy to find a job (42.7%, n=91) and a higher salary and better benefits (44.1%, n=94) were the most important reasons, followed by ease of finding a job (35.2%) and helping the family financially (33.3%) (Table 2.3).

Table 2.3: Reasons for Studying Nursing

Reasons	Yes	No	Most important	Second most important
	n(%)	n(%)	n(%)	n(%)
1. Ease of finding a job/employability	91(42.7)	122(57.3)	75(35.2)	33(15.5)
2. Help the family financially	62(29.1)	151(70.9)	71(33.3)	33(15.5)
3. Higher salary and better benefits	62(29.1)	151(70.9)	94(44.1)	34(16.0)
4. Provide service to the sick and needy	60(28.2)	153(71.8)	57(26.8)	34(16.0)
5. Work overseas	43(20.2)	170(79.8)	34(16.0)	49(23.0)
6. Gain self-confidence in decision-making	35(16.4)	178(83.6)	23(10.8)	32(15.0)
7. Family encouragement	25(11.7)	188(88.3)	19(8.9)	38(17.8)
8. Was not admitted to other courses such as medicine	25(11.7)	188(88.3)	9(4.2)	43(20.2)
9. Parent/relative is a nurse	21(9.9)	192(90.1)	19(8.9)	32(15.0)
10. Achieve better social status	15(7.0)	198(93.0)	22(10.3)	36(16.9)
11. Likes the uniform	14(6.6)	199(93.4)	17(8.0)	34(16.0)
12. Escape from social pressure at home	5(2.3)	208(97.7)	10(4.7)	36(16.9)
13. Find a better spouse such as a medical doctor	2(0.9)	211(99.1)	5(2.3)	37(17.4)

Changes in Life Before and After Working as a Nurse in Another Country

Most participants experienced changes in their economic status (92.0%, n=196) after working as a nurse in other countries. More than half experienced changes in their professional (63.8%, n=136), social (50.7%, n=108), and family life (57.7%, n=123) upon migrating. Most indicated they planned to work in another country (71.8%, n=153) after the contract. Table 2.4 shows life before and after working as a nurse in another country.

Table 2.4: Changes in Life Before and After Working as a Nurse in Another Country

Changes	n(%)
Economic	196(92.0)
Professional	136(63.8)
Family life	123(57.7)
Social	108(50.7)
Plan to work in other countries	153(71.8)

Current Feeling About the Decision to Choose Nursing as a Profession

Table 2.5 shows how participants feel about their decision to become a nurse. Most said they were happy (83.1%, n=177).

Table 2.5: Current Feeling About the Decision to Choose Nursing as a Profession

Emotion	n(%)
Very unhappy	12(5.6)
Unhappy	1(0.5)
Neither happy nor unhappy	23(10.8)
Happy	80(37.6)
Very happy	97(45.5)

Challenges of Being a Nurse in Malaysia

Most nurses said they did not experience difficulties dealing with patients (75.6%) and occupational hazards (70.9%) in Malaysia, whilst 96 participants (45.1%) said that low salaries and poor benefits were incredibly problematic. Connections and/or corruption in getting work and promotion (68.5%, n=146), a high ratio of patients to nurses (67.6%, n= 144), poor working conditions (61.5%, n=131), and complicated relationship with superiors and fellow workers (51.2%, n=109) were the main difficulties of working in Malaysia. Inadequate facilities or infrastructure in hospitals (58.2%, n=124) caused problems. Table 2.6 details the adversities faced by the participants.

Table 2.6: Distribution of Difficulties Experienced by Nurses in Malaysia

	n(%)					
Difficulties	1	2	3	4	Mean	SD
Dealing with patients	75(35.2)	86(40.4)	38(17.8)	14(6.6)	3.05	1.03
Occupational hazards	56(26.3)	95(44.6)	36(16.9)	26(12.2)	2.90	0.95
Limited opportunities for career advancement	31(14.6)	60(28.2)	69(32.4)	53(24.9)	2.85	0.93
High ratio of patients to nurses	20(9.4)	49(23.0)	86(40.4)	58(27.2)	2.77	1.02
Low salary/few benefits	23(10.8)	39(18.3)	55(25.8)	96(45.1)	2.67	1.01
Connection/corruption in getting work and promotions	20(9.4)	47(22.1)	81(38.0)	65(30.5)	2.61	0.94
Inadequate facilities/infrastructure in hospitals	32(15.0)	57(26.8)	87(40.8)	37(17.4)	2.46	0.96
Poor working conditions (heavy tasks, long hours, night shift)	29(13.6)	53(24.9)	69(32.4)	62(29.1)	2.21	0.98
Difficult relationship with superiors and fellow workers	41(19.2)	63(29.6)	78(36.6)	31(14.6)	2.15	0.95
Lack of nursing skills and knowledge (competencies in nursing)	59(27.7)	73(34.3)	57(26.8)	24(11.3)	2.04	1.01
Gender discrimination by patients	88(41.3)	59(27.7)	46(21.6)	20(9.4)	1.99	1.00
Gender discrimination by management	82(38.5)	62(29.1)	47(22.1)	22(10.3)	1.96	0.89

SD = standard deviation

1. Not at all difficult, 2. Not particularly difficult 3. Fairly difficult 4. Extremely difficult

Note: Total mean satisfaction score 29.68±SD8.33

Table 2.7 shows the association between the total score of challenges of being a nurse in Malaysia and demographics and nursing characteristics. The five components of demographics and nursing characteristics—first nursing qualification, highest academic degree, experience in nursing, length of

time working abroad, and type of workplace—were significantly associated with the challenges, with a P-value of ≤ 0.05.

Table 2.7: Association Between Total Mean Score of Difficulties Being a Nurse in Malaysia and Nursing Characteristics

Characteristics	Mean	SD	df	f	P
Religion[b]			4	1.01	0.40
Hindu	32.06	8.05			
Christian	27.41	8.10			
Muslim	29.92	8.64			
Buddhist	29.67	6.25			
Sikh	30.33	1.53			
First nursing qualification[b]			2	5.60	0.004*
Certificate in nursing	26.45	6.35			
Diploma in nursing**	28.87	7.61			
Bachelor's degree	33.00	9.99			
Highest academic degree[b]			3	4.41	0.005*
Postgraduate	28.50	8.99			
Bachelor's degree	31.09	8.88			
Post-basic or bachelor of science	26.15	8.50			
Diploma/General	30.74	5.49			
Current marital status[b]			2	0.89	0.41
Single	29.60	8.21			
Married	30.15	8.47			
Widowed/Separated/Divorced	27.45	8.06			
Experience in nursing (Year) [b]			3	6.99	0.001*
≥ 5	32.38	8.67			
6–10	32.26	8.80			
11–15	26.98	7.59			
≥ 16	27.57	6.95			
Length of time working abroad (years)[b]			3	2.81	0.04*
≤1	27.18	8.46			
>1–3	31.69	8.42			
>3–5	29.75	7.15			
>5	30.24	8.45			
Previously migrated[a]				3.35	0.07
Yes	28.36	9.97			
No	29.88	8.06			
Type of workplace[b]			2	7.86	0.001*
Government	28.79	7.19			
Semi-government	34.79	10.93			
Private	28.36	9.06			

Note: Difficult experience total mean score 29.68±SD8.33.

*p ≤ 0.05 considered statistically significant.

**The nursing programme increased the curriculum's theory components to 50% in 1992. Thus, nurses enrolled in the nursing programme after 1992 received a diploma in nursing. Before 1992, nurses graduated with a certificate in nursing.

[a] Independent t-test.

[b] One-way independent analysis of variant.

5. Job Satisfaction Level of Malaysian Nurses Working in Other Countries

Of the 213 participants, 165 (77.5%) were satisfied working in other countries. Many participants were satisfied serving the sick and needy (74.6%, n=159) and with the ease of finding a job (72.3%, n=154). About 69.5% were satisfied with the degree of self-respect, salaries, and benefits. About 65.3% were satisfied with the relationship with fellow nurses and superiors and 61% were gratified with career development, including promotion. Nearly 43.2% (n=92) were satisfied with children's education or childcare. The total mean satisfaction score was 28.00±SD6.03, excluding participants who indicated that the component did not apply to them. Table 2.8 details the participants' satisfaction level.

Table 2.8: Malaysian Nurses' Satisfaction Level Components

	n(%)					
Components	1	2	3	NA	Mean	SD
1. Serving the sick and needy	6(2.8)	36(16.9)	159(74.6)	12(5.6)	2.61	0.80
2. Social status of nurses	37(17.4)	55(25.8)	109(51.2)	12(5.6)	2.23	0.93
3. Working in other countries	6(2.8)	33(15.5)	165(77.5)	9(4.2)	2.66	0.73
4. Ease of finding a job/employability	8(3.8)	47(22.1)	154(72.3)	4(1.9)	2.65	0.65
5. Degree of self-respect	17(8.0)	46(21.6)	148(69.5)	2(0.9)	2.60	0.67
6. Salaries and benefits	36(16.9)	25(11.7)	148(69.5)	4(1.9)	2.49	0.84
7. Relationship with fellow nurses and superiors	16(7.5)	53(24.9)	139(65.3)	5(2.3)	2.53	0.74
8. Career development including promotion, training	21(9.9)	54(25.4)	130(61.0)	8(3.8)	2.44	0.82
9. Working conditions (working hours, night shifts)	25(11.7)	56(26.3)	127(59.6)	5(2.3)	2.43	0.79
10. Children's education/child-rearing (if any)	18(8.5)	38(17.8)	92(43.2)	65(30.5)	1.74	1.29
11. Care for parents-(in-law) (if any)	22(10.3)	36(16.9)	98(46.0)	57(26.8)	1.82	1.27
12. Relationship with spouse (if any)	15(7.0)	33(15.5)	102(47.9)	63(29.6)	1.82	1.31

NA = not applicable, SD = standard deviation

1. Dissatisfied. 2. Neither dissatisfied nor satisfied. 3. Satisfied.

Note: Total satisfaction score 28.00± 6.03.

6. Association between Job Satisfaction Level and Sociodemographic Characteristics

One-way independent ANOVA and independent t-test showed no significant association between total satisfaction score and sociodemographic characteristics of the nurses except for first nursing education and job satisfaction level of those working in other countries (p=0.05). Table 2.9 shows the

detailed analysis of the distribution of association between sociodemographic status and job satisfaction level.

Table 2.9: Association Between Job Satisfaction Level and Sociodemographic Characteristics of Malaysian Nurses Working in Other Countries

Characteristics	Mean	SD	df	f	P
Religion (n=213)	28.00	6.03	4	0.32	0.87
Hindu	29.00	8.05			
Christian	27.97	8.10			
Muslim	28.02	8.64			
Buddhist	27.27	6.25			
Sikh	25.33	1.53			
First nursing qualification			2	3.11	0.05*
Certificate	30.27	5.69			
Diploma	28.38	5.69			
Bachelor's degree	26.27	6.87			
Highest academic degree			3	1.23	0.30
Postgraduate	29.61	4.43			
Bachelor's	27.23	6.21			
Post basic	28.75	6.27			
Diploma	28.20	5.89			
Current marital status			2	0.80	0.45
Single	27.35	6.39			
Married	28.38	5.73			
Widowed/Separated/Divorced	28.60	6.21			
Experience in nursing (years)			3	1.46	0.23
≥ 5	28.28	5.38			
6–10	26.68	5.63			
11–15	28.49	7.05			
≥ 16	28.75	5.82			
Length of time working abroad (years)			3	0.68	0.57
≤1	28.43	6.43			
>1–3	27.12	5.83			
>3–5	27.58	6.85			
>5	28.53	5.34			
Previously migrated				3.28	0.07
Yes	27.25	8.28			
No	28.11	5.64			

*p ≤ 0.05 considered as statistically significant.

[a] Independent t-test.

[b] One-way independent analysis of variant.

7. Discussion

Factors in Malaysian Nurses' Decision to Migrate to Other Countries

The study described the factors in Malaysian nurses' decision to migrate to other countries and reported job satisfaction. Most nurses (96.7%) said the main reason for deciding to work in other countries was high salaries and better benefits; 82.6% cited higher salaries and better benefits as the

most important reason, followed by the opportunity to attain a high level of nursing skills and technology (47.9%) and better quality of life (38.5%).

In Malaysia, the minimum basic nursing salary for a newly appointed Grade U29 nurse with diploma qualification is RM1,797 per month and a RM145 increment per year (Malaysian Civil Service Commission, 2021a). Nurses with a bachelor's degree can apply for Grade U41, with a basic salary of RM2,426 per month and a yearly increment of RM225 (Malaysian Civil Service Commission, 2021b). However, most nurses with a bachelor's degree are commonly in Grade U29 because U41 posts are limited. The average basic annual income for Grade U29 is about RM21,564 and for Grade U41 RM29,112. Malaysian nurses working overseas commonly earn triple the salaries they could earn in Malaysia (Lajiun, 2016).

The shortfall of nurses in Malaysia is mainly caused by low wages. In Singapore, newly graduated Malaysian nurses are offered almost SGD3,000 per month, but in public and private hospitals in Malaysia only SGD670 a month (Augustin, 2017). The International Council of Nurses Workforce Forums said that starting salaries in Asian countries appeared to start slightly lower in 2013 (Catton, 2018). In 2015 and 2016, salaries apparently stagnated and declined.

The high salaries paid in other countries pull Malaysian nurses to work there. The study shows that nurses working in Malaysia are paid less than those in other countries, where salaries are triple those in Malaysia. Nurses elsewhere migrate to seek better wages, improved working conditions, and higher living standards than in their own countries (Kline, 2003). The economic and social status of Indian nurses, for example, improves significantly after working abroad (Oda, Tsujita, and Rajan, 2018). Besides higher salaries, job security and improved social status after working abroad most satisfy nurses (Oda et al., 2018).

Job Satisfaction Level of Malaysian Nurses Working in Other Countries

The study found that most Malaysian nurses were satisfied with their current position in other countries. Most said they were working in government hospitals, which they perceived as giving them job security. In Maslow's (1943) hierarchy of needs, unmet safety needs can be just as important as unfulfilled physiological needs. Psychological safety needs, including job security, work–life conflicts, and occupational stress, are emerging threats to nursing job security (Staempfli and Lamarche, 2020). A study of data from the 1990s, when funding to the California healthcare system was significantly cut, found that threats to job security diminished job satisfaction (Burke, Ng, and Wolpin, 2015). Most participants in the present study reported that their lives changed economically (92%) and professionally (63.8%), and as did their family life (57.7%) after working in other countries. A qualitative study in the United States found that similar factors influenced graduating nursing students' and practicing nurses' intent to stay in their homeland or workplaces, including competitive pay and benefits, positive work environment, and personal and professional development (Owens, Burwell, Deese, and Petros, 2021).

Association Between Job Satisfaction of Malaysian Nurses and Nurse Characteristics

The study provides valuable insights into the association between job satisfaction and the first nursing qualification. Although most nurses (77.5%) working abroad have only certificates or diplomas for

their first nursing qualifications, they have higher salaries and better benefits than other health science professionals with a bachelor's degree and working in Malaysia. Amongst the participants, one is a director, four are nursing administrators, and three are nurse educators, indicating that nurses from Malaysia have opportunities for promotion in healthcare organisations abroad. The study is congruent with Troy, Wyness, and McAuliffe (2007): The nursing profession is a passport to opportunities to work in any country. Threats to job security and lack of career advancement cause negative job satisfaction (Staempfli and Lamarche, 2020). Malaysian nurses demonstrate higher satisfaction working overseas because they are entitled to employee benefits and career advancement opportunities. They have the chance to develop their careers by practicing and learning a high standard of nursing skills, which increases their job satisfaction and fulfils their needs (Kline, 2003; Staempfli and Lamarche, 2020).

Job satisfaction is significant in nurses' intention to leave Malaysia. A study in a teaching hospital reported that 40% of staff nurses intended to leave their jobs, the most critical determinant being a low degree of satisfaction (Ramoo, Abdullah, and Piaw, 2013). Malaysian nurses tend to feel more empowered and committed to their organisation in Malaysia than their foreign counterparts in other countries, but are less likely to be satisfied with their jobs (Ahmad and Oranye, 2010). In Malaysia, updating nursing knowledge and providing quality care are the most critical factors motivating nurses to continue professional education (Chong, Sellick, Francis, and Abdullah, 2011). Therefore, the career development pathway for nurses must be examined, including their motivation, job satisfaction, and perspectives, to retain them in Malaysia.

Most Malaysian nurses are educated and fluent in English, allowing them to communicate effectively with other healthcare providers, patients, and their families abroad and helping them adapt to their superiors and colleagues. Non–English-speaking nurses had lower job satisfaction (Timilsina Bhandari, Xiao, and Belan, 2015). Workplace language barriers disrupt nurses' interactions with patients and colleagues. This finding shows the importance of group cohesion in influencing job satisfaction (Staempfli and Lamarche, 2020).

Association Between Difficulties Working in Malaysia and Nurse Characteristics

The study found that nurses' main difficulties are related to connections and/or corruption in employment and promotions (68.5%, n=146) and to professional relationships with superiors and fellow workers (51.2%, n=109). A previous survey on emotional exhaustion showed that it stemmed from job demands, lack of supervisor support, and work–family conflict (Rhéaume, 2021). The present survey found that organisational resources can positively affect employee well-being. Decision latitude and managerial support decrease work–family conflict, suggesting that a work environment that fosters nurse autonomy and policies that support nurses can improve nurses' well-being. The study found that nurses who choose to work in other countries may want to avoid the challenges they encountered in Malaysia.

Participants' other major difficulties are the high ratio of patients to nurses (67.6%, n= 144) and poor working conditions (61.5%, n=131). An international survey of 6,212 registered nurses in seven countries determined staff characteristics, working environment, absenteeism, and intention to leave (Burmeister et al., 2019). It found that nurses' perception of staffing adequacy greatly influenced their intention to leave regardless of country and staff characteristics. Nursing staffing was identified as a

significant predictor of absenteeism and intent to leave, with a 25% higher rating of perceived staffing adequacy associated with lower odds of absenteeism and intention to leave. The international survey findings pointed to staffing adequacy as a critical variable in nurse retention.

The present study found a significant association between challenging work experiences in Malaysia and first nursing qualification ($p \leq 0.004$), highest nursing qualification ($p \leq 0.005$), experience in nursing ($p \leq 0.001$), length of time working abroad ($p \leq 0.04$), and type of workplace ($p \leq 0.001$). Nurses who were offered work in other countries with their first nursing qualification or those who gained higher qualifications after working overseas looked for a better working environment. Ninety-six nurses (45.1%) indicated that low salaries and poor benefits were incredibly problematic. The challenging work in Malaysia and low salaries could be unbearable, pushing nurses to find work in other countries.

The study found an association between challenging work experience in Malaysia and length of time working overseas. Most of the nurses worked in government or semi-government agencies, which provided them with a sense of job security, directly improving their psychological safety. The absence of psychological safety, caused by a lack of career development opportunities and poor working conditions, is a threat to self-actualisation (Kline, 2003; Staempfli and Lamarche, 2020). Conflicts with superiors delay staff appointment or promotion, which can discourage nurses from serving in Malaysia. Attentive and supportive supervisors help improve the workplace environment (Shier, Turpin, Nicholas, and Graham, 2021). Higher salaries, better benefits, and a supportive work environment remain the key contributors to Malaysian nurses' satisfaction in other countries (Timilsina Bhandari et al., 2015; Tsujita, 2018).

A systematic review to identify factors that influence the decision of experienced nurses to leave or remain in acute care work found that inadequate conflict management, lack of support, poor work environment, overcrowded work schedules, and disproportionate staffing levels lead to demoralisation and burnout (Hollis, 2019). The findings showed the importance of positive administrative change in retaining experienced nurses and in improving the mentoring of newer nurses, which ultimately help improve patient outcomes. Some nurses decide to retire early or leave the profession because of the work intensity and poor working conditions (Catton, 2018). Nurses in the present study reported that inadequate facilities or infrastructure in hospitals (58.2%, n=124) in Malaysia made work difficult, but most nurses said they had no difficulties dealing with patients (75.6%) and occupational hazards (70.9%).

The present study provides a general overview of job satisfaction amongst Malaysian nurses working in other countries. It emphasises the importance of employers and managers in ensuring that nurses are always satisfied in their workplace. Management teams should continue supporting nurses and maintaining a good working environment and positive relationships. Employers and managers should be more aware of factors that affect nurses' job satisfaction, such as self-respect, relationships with colleagues, and career development, which management teams should prioritise. Malaysia is just one country that will face a lack of nurses over the next 1–10 years as they migrate to other countries (Matsuno, 2009). The ageing population and a nurse shortage are significant concerns in many countries, including Malaysia (Walani, 2015). Malaysia needs more nurses. Their contributions should be recognised and appreciated by providing them with better job security and respect. Given that working abroad is more attractive than working in Malaysia, we suggest that the government take further action to retain them in the country (Matsuno, 2009).

Limitations

The cross-sectional research design of the study provided information about the challenges of nurses in Malaysia and their job satisfaction in other countries at a point in time. The design may have problems inferring changes and trends over time concerning job satisfaction (Polit and Beck, 2020). Purposive and snowball sampling methods used may not be generalisable. Self-report bias such as dishonest answers and differences in understanding and interpretation of the questions may exist when survey questionnaires are used (Polit and Beck, 2020).

8. Conclusions

The study provides an overview of job satisfaction of Malaysian nurses and why they work abroad. Overall, they are satisfied in other countries. They choose to work abroad mainly because of the high salaries and better benefits. The challenges they face in Malaysia can be a factor pushing them to work in other countries. There are no significant differences in sociodemographic status and job satisfaction of nurses in Malaysia and Malaysian nurses working abroad except the first nursing qualification. There are significant differences in nurses' sociodemographic status and challenges in Malaysia, including first nursing qualification, highest qualification, length of service as a nurse, length of time working overseas, and type of place they work in other countries. The preliminary findings on Malaysian nurses' migration may guide the Public Service Department, the Ministry of Health, and the Nursing Board to develop effective strategies, including fostering a healthier work environment, reviewing nurses' salaries, expanding career opportunities, and enhancing job security. Such measures will resolve issues such as nursing scarcity and improve the quality of patient care.

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Chapter 3
Obtaining a Nursing Job in Australia and New Zealand: A Case Study of Migrant Nurses Trained in India

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Many developed countries face a shortage of nurses and open their labour markets to foreign-trained nurses, adopting different recruitment methods. The literature mainly discussed the recruitment of foreign-trained nurses from the nurse-receiving country's point of view and paid little attention to that of the recruited. This chapter demonstrates how foreign-trained nurses, focusing on India-trained migrant nurses, obtain nursing jobs in Australia and New Zealand, and some issues and problems from migrant nurses' point of view, based on semi-structured interviews.

In both countries, the percentage of foreign-trained nurses is on the rise because of the shortage of nursing professionals, and the growing ageing population. To migrate to Australia or New Zealand and practice nursing, foreign nurses must be registered with the countries' nursing boards. Registration is required to complete a nursing board–approved bridging programme for those who study nursing in most Asian countries, including India.

From the Indian nurses' point of view, application and assessment are more complicated in Australia than in New Zealand. Both countries have changed their assessment and immigration systems, which is mainly why foreign-trained nurses rely on recruitment agents, raising the cost of migration. Nurse-sending families are well-off. It is a household strategy to send a nurse to Australia and New Zealand. Once the sampled nurses were registered, they sent for their families. Marrying a man off to a migrating nurse is a strategy for the man's family to have access to developed countries. But finding a reasonably good job for the spouse is not easy, particularly in New Zealand.

The overwhelming majority of the sampled nurses chose New Zealand because their English scores met its requirements. Some foreign-trained nurses regard New Zealand as a steppingstone to Australia. The Trans-Tasman Mutual Recognition Agreement is a double-edged sword. Through it, New Zealand attracts those who would like to go to Australia, and they might leave for Australia after some time. Some policy implications are discussed based on our findings.

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1. Introduction

Many developed countries face a shortage of nurses because of the ageing population, growing demand for better health services, the shift of family or home care to institutional care, the turnover and ageing of local nurses, and the promotion of medical tourism, amongst other reasons. Most developed countries open their labour markets to foreign-trained nurses to fill such shortages. On average, 14.5% of the nursing workforce was born abroad in Organisation for Economic Co-operation Development (OECD) member countries (OECD, 2015). International migration has accelerated through a wide range of recruitment methods.

Traditionally, those who have an overseas nursing qualification are often required to be assessed by the authority in the destination country (Kingma, 2006). One assessment method is taking the licensing or qualification exam in the destination country. The method is still valid but some countries hold exams in another country. For example, the United States (US) National Council of State Boards of Nursing registered nurses exam can be taken outside the US, including in Hong Kong, India, Japan, the Philippines, and Taiwan. The other method is the conduct of a series of assessments by the nursing authority and/or nursing authority–accredited institutions in some nurse-receiving countries. Some nurses are easily recognised as a registered nurse in the destination country based on their qualifications in the place of origin, but others are required to take training courses, so-called bridge courses, to register as a nurse.

Besides the traditional assessment methods, nurses are recruited through a multinational, regional, or bilateral trade agreement. Free trade agreements increasingly include labour-related clauses (Yeats and Pillinger, 2019). Mutual recognition agreements (MRAs) allow qualified nurses to practice in other countries through mutual recognition of their qualifications. MRAs, however, do not mean automatic recognition by all states joining such MRAs, and the practical application of MRAs varies from one state to another. The Caribbean Community (CARICOM) has unified the nursing education curriculum and qualifications. Thus, nurses in CARICOM countries may work in any participating country without additional qualifications or assessments. The Trans-Tasman MRA of 1997 enables Australian nurses to work in New Zealand and vice versa, although they do not have the same nursing curriculum and have separate registration systems. The Association of Southeast Asian Nations (ASEAN) MRA on nursing services, which was signed and came into force in December 2012, has facilitated nurses' mobility to only a few countries. Trade agreements may include a clause on mobility of people, allowing preferential access to one country (or more than one country) for some nationals. For example, Japan's economic partnership agreements allow Japan-qualified nurses and care workers from the Philippines, Indonesia, and Viet Nam to practice in Japan and work and reside there without limitation. Under the Triple Win project, Germany employs nurses from Serbia, Bosnia and Herzegovina, the Philippines, Indian state of Kerala, Tunisia, Indonesia and Jordan through employment agencies. Many nurse-receiving countries adopt different recruitment methods for foreign-trained nurses.

The literature mainly discussed recruitment of nurses from the point of view of nurse-receiving countries and not the recruited. This chapter demonstrates how foreign-trained nurses, with a focus on India-trained migrant nurses, get nursing jobs in Australia and New Zealand. It shows

some issues and problems from migrant nurses' point of view, based on semi-structured interviews. The proportion of foreign-trained nurses in the nurse workforce is high: 18.4% in Australia and 26.4% in New Zealand (Organisation for Economic Co-operation and Development), which employ assessment systems.

Indian migrant nurses are defined as registered nurses in Australia or New Zealand, who were born in India, studied nursing there, and had or have a nursing license there. We conducted semi-structured interviews with India-trained migrant nurses from September 2019 to March 2020. The questions included personal background, educational experience, clinical experience in India, job history, migration to Australia or New Zealand, the process of becoming a registered nurse, current problems faced in the destination country, and so on. We employed the snowball sampling method because we lacked access to nursing registrars in both countries. The survey had 14 participants in Melbourne, Australia, and 13 in Christchurch, New Zealand, all female. They were usually interviewed at home, in English, for about 60 minutes on average. The interviews were audio-recorded and transcribed. This chapter focuses on registered nurses, although nurses in both countries include registered nurses, enrolled nurses, and nursing practitioners. The description in this chapter is confined to the period prior to the COVID-19 pandemic.

2. Australia

2.1. Overview of Nurse Migration to Australia

Australia has been a major destination country for migrants such as nurses because of its relatively open immigration policy, moderate climate, and better working environment. Demand is rising for skilled workers. Like other developed countries, Australia has a shortage of nurses, particularly in critical care, midwifery, aged care, and mental health. Health Workforce Australia (HWA) (2014) projected a shortfall of 85,000 registered and enrolled nurses by 2025, estimated to increase to 123,000 by 2030. Migrant nurses from overseas have been important in filling the shortage.

OECD reports statistics on health professionals in its member countries, including foreign-trained nurses in destination countries. Caution is necessary in interpreting the figures, as there are two categories of foreign-trained nurses: foreign-trained foreign-born nurses, and foreign-trained native-born nurses.[2] Except in a few countries such as Israel and Norway, foreign-trained native-born nurses are far fewer than foreign-trained foreign-born nurses. In this chapter, for simplicity, all foreign-trained nurses are considered trained and born abroad. As of 2017, Australia had 52,860 foreign nurses. Amongst 21 OECD countries, Australia has the third-largest population of foreign nurses after the United Kingdom (UK) (103,671) and Germany (71,000) (OECD). The proportion of foreign nurses in Australia was 14.5% in 2007, increasing to 18.4% in 2017, the

[2] Some nurses were born abroad and trained in the receiving country. They are not categorised as foreign trained.

third largest amongst OECD countries after New Zealand (26.0%) and Switzerland (25.9%).

In 2017, nurses from the UK formed the largest group of foreign nurses in Australia (14,370, 27.2%), followed by nurses from India (10,052, 19.0%) and the Philippines (7,835, 14.8%) (Table 3.1). New Zealand has provided a stable source of nurses for Australia. Whilst the population of UK-trained nurses is the largest, it has generally remained constant. However, the numbers of Indian and Filipino nurses are quickly increasing. From 2013 to 2017, Indian nurses increased by more than 60% and Filipinos by close to 70%. The trend seems to be continuing.

Table 3.1: Stock Foreign-trained Nurses in Australia

Year	2007	2008	2009	2013	2014	2015	2016	2017
Country of origin								
Canada	..	..	..	452	514	502	530	539
China	..	..	..	1063	1228	1283	1328	1397
India	..	..	..	6237	7713	8468	9169	10052
Ireland	..	..	..	1847	2039	2090	2088	2108
Malaysia	..	..	..	200	202	177	177	183
New Zealand	5248	5691	5834	6404	6491	6398	6915	6847
Philippines	..	..	..	4628	5734	6235	6941	7835
South Africa	..	..	..	1725	1879	1884	1871	1813
Sri Lanka	..	..	..	65	83	84	85	86
United Kingdom	..	..	..	14009	14916	14562	14452	14370
United States	..	..	..	459	543	515	548	547
Zimbabwe	..	..	..	1149	1276	1288	1322	1344
Others (not elsewhere classified)	32860	31958	33141	6045	5915	5640	5754	5739
Total	38108	37649	38975	44283	48533	49126	51180	52860

Data extracted on 22 Feb 2020 11:05 UTC (GMT) from OECD.Stat

Source: Organisation for Economic Co-operation and Development statistics (accessed 22 February 2020).

2.2. Factors Influencing Nurse Shortages

Multiple factors have caused the shortage of nurses in Australia. Demographic changes are a major one. First, Australia's population is ageing. The ratio of the population aged 65 and above to the total was 12.3% in 1999, increasing to 15.9% in 2018 (Australia Bureau of Statistics), and expected to grow to 22% by 2056 (Government of Australia). Second, the population was growing at 1.5% in 2019, high amongst developed countries. The country's growing ageing population demands more health professionals, including nurses.

At the same time, the nursing occupation is undergoing a demographic change. Whilst the average age of nurses marginally increased from 44.3 in 2009 to 44.6 in 2012, the ratio of aged nurses increased. The proportion of nurses aged 55 and over in Australia was 19.8% in 2009, rising to 23.1% in 2012 (HWA, 2014). This ageing trend is reported to continue and indicates the imminent retirement of experienced and skilled older nurses, which will impact not only quantity but also the overall quality of nursing professionals.

High turnover rates amongst nurses contribute to shortages. Because nursing jobs are physically and mentally demanding, high turnover is not particular to Australia, where it has been reported

at about 30% (Commonwealth of Australian, 2002).

From our interviews with nurses in Australia, we concluded that the shortage might be a consequence of Australians' way of life. Australians usually work a maximum of 40 hours per week. One reason is that they value work–life balance and health. Another is that they simply want to avoid the higher tax rate imposed on additional work hours because their net-income increase is marginal.

Rising demand for and declining supply of nurses have caused the nursing shortage.

2.3. Pathway for Foreign Nurses to Become a Registered Nurse in Australia

To mitigate the negative economic and social impacts of skilled-labour shortages, the government initiated the General Skilled Migration (GSM) Programme to expand immigration policies and improve the workforce. The GSM is a visa-issuing programme that prioritises skilled workers willing to migrate to Australia. The GSM lists 512 types of jobs as 'skilled occupations' that are in demand and includes 20 nursing and midwifery occupations such as midwife, registered nurse for aged care, and registered nurse for critical care and emergency (see the Appendix for the complete list of nursing and midwifery occupations and Australian Government (not dated) for the complete list of skilled occupations).

To apply for a skill-migration visa specified under the GSM, nurses must be registered with the Nursing and Midwifery Board of Australia (NMBA), which is the formal association of nurses and midwives in Australia. Then they must be skill-assessed by the Australian Nursing and Midwifery Accreditation Council (ANMAC), an independent body gazetted by the minister for immigration. The Australian Health Practitioner Regulation Agency (AHPRA) works with 15 national boards of health professionals to maintain quality health services and assesses registration applications from overseas nurses and midwives on behalf of the NMBA. ANMAC assesses skills of nurses migrating to Australia under the GSM programme and determines if their qualifications and experience are sufficient for permanent migration. AHPRA assesses nurses for registration and ANMAC assesses them for potential immigration.

Registering with the NMBA is the most important step in migrating to Australia. ANMAC's role is not clear. One migrant nurse from the UK we interviewed did not know that her qualifications and experience had been assessed by ANMAC after registration; she did not even know what ANMAC was. Other migrant nurses talked about their dealings with AHPRA and the NMBA for registration but almost nobody mentioned ANMAC's skills assessments. We never met nurses who had registered but failed to pass ANMAC's skills assessment. Thus, ANMAC's function in the migration procedure is not visible.

2.4. Qualified Nurses from New Zealand and English-speaking Countries

The nurse-registration procedure is not the same for everyone and depends on where the migrating nurses come from and their qualifications. There are three pathways to

registration in Australia: for nurses registered in New Zealand, nurses registered in specified English-speaking countries, and the rest.

Registration with the NMBA is simple for nurses registered with the Nursing Council of New Zealand or the Midwifery Council of New Zealand, as nurse certification between the two countries is transferrable because of the Trans-Tasman MRA. This simple procedure may encourage New Zealand–registered nurses to practice in Australia; New Zealand, therefore, has provided a stable source of nurses to Australia.

Nurses trained in five English-speaking countries—the US, the UK, Ireland, Canada, and Hong Kong—enjoy a fast track to nursing registration in Australia, although not as simple as the process for New Zealand–registered nurses. Although a more detailed skills assessment by ANMAC may be required, it is not complicated for nurses with bachelor of science (BSc) degrees from those countries to register as long as they satisfy all of AHPRA's registration standards. These are composed of four categories: criminal history, English-language skills, recency of practice, and professional indemnity insurance arrangement, since the NMBA considers nursing qualifications issued by education institutions in the five countries to be *likely* to meet the requirements for quality assurance and accreditation.[3]

2.5. Nurses from Countries Other than New Zealand and English-speaking Countries

Most nurses migrating from abroad fall into this category, including India- and Philippines-trained nurses, who are rapidly increasing their presence in Australia. Since the programme offered in educational institutes in countries other than New Zealand and the five mentioned English-speaking countries are not likely to meet the criteria set by the NMBA, nurses with a BSc in nursing and those registered as nurses in those countries follow a different path (Figure 3.1). Until the end of 2019, nurses from those countries who applied to AHPRA for registration were directed to take an NMBA-approved bridging programme to become eligible.

The bridging programmes are Initial Registration of Overseas Nurses (IRON) or Entry Program for Internationally Qualified Nurses (EPIC), depending on their location. They usually last 12–24 weeks, costing at least AUD12,000. After completing a bridging programme, a nurse is qualified for registration. Subsequently, his or her skills are assessed by ANMAC for immigration. Nurses with diplomas are not admitted to bridging programmes and must take undergraduate courses from an Australian university for 1–2 years before applying to AHPRA and bridging programmes.

A major problem facing nurses from non–English-speaking countries is their English-language skills. To apply for registration, an applicant must satisfy the registration standard, which includes

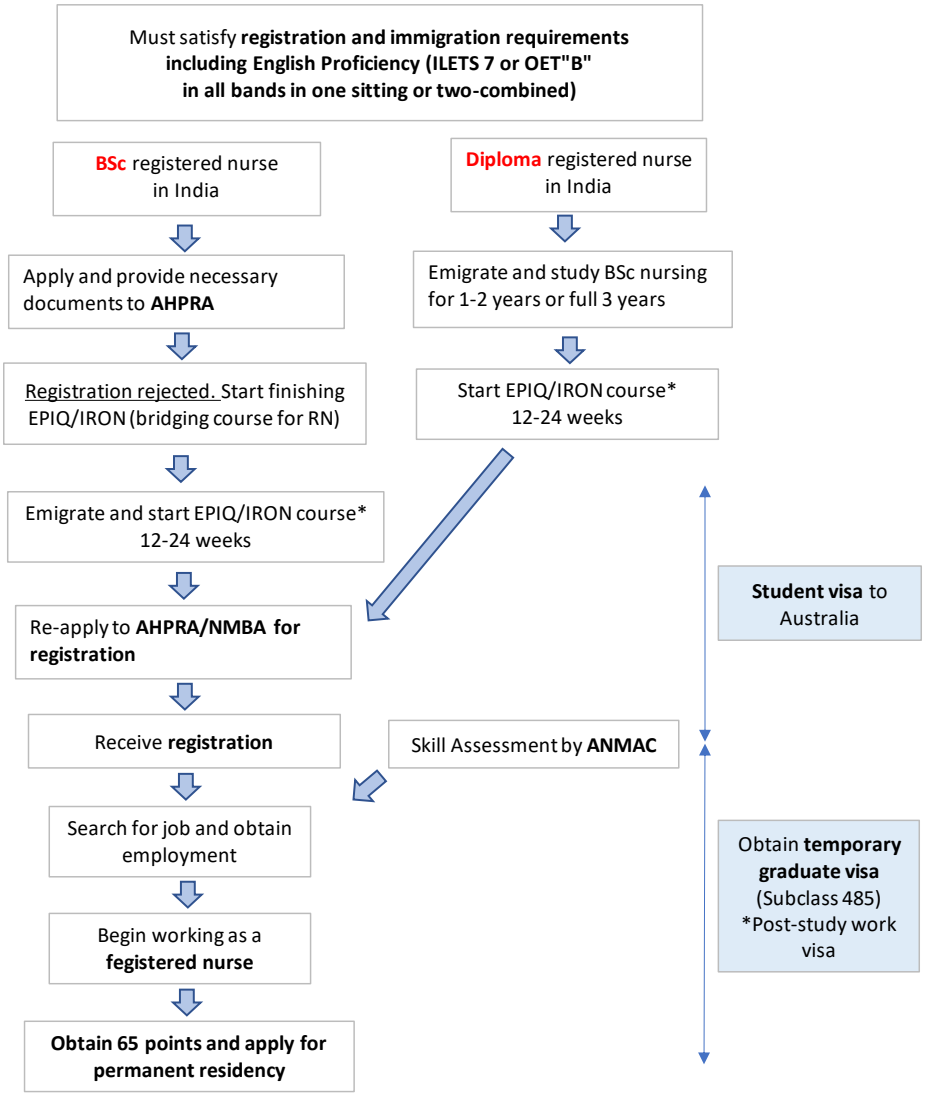
[3] The NMBA has found that nursing qualifications issued by education institutions in Belgium Flanders, Chile, Pakistan, Papua New Guinea, and Singapore *may* meet the requirements for quality assurance and accreditation.

English-language skills. The minimum level of English is at least 7.0 in all four bands (listening, reading, writing, and speaking) of IELTS or at least B in all modules of the Occupational English Test (OET). The scores have been clubbed since 2016; that is, satisfactory scores can be achieved over two test sittings. However, the minimum overall score of at least 7.0 must be maintained, both tests must be taken within 6 months of each other, and no module score must be below 6.5 across both sittings. Many Indian nurses have difficulty obtaining 7.0 in writing. Before 2016, a score of at least 7.0 in all four modules on one test was required. This strict rule discouraged foreign nurses from non–English-speaking countries from applying to Australia. They chose instead to migrate to New Zealand, which accepted clubbed scores.

Another issue is that seats for IRON and EPIC bridging programmes are limited. Bridging programmes offered in cities and convenient locations quickly fill up. Therefore, nurses must wait a long time to enrol, in addition to the waiting period during the initial application procedure to AHPRA. After registration is complete, potential migrants must wait about 2 months to receive their ANMAC skills assessments to qualify for a visa. The duration from the migrant's initial application to his or her ANMAC skills assessment could be significant.

The registration procedure has undergone major changes since mid-March 2020. It is in transition for a couple of years. Bridging programmes are being replaced by a new scheme. Those currently enrolled or those who have been accepted and are expecting to enrol, however, are on the old track to nurse registration. Details on the new scheme have not been revealed as of this writing.

Figure 3.1. Steps for Nurse Registration until the End of 2019



AHPRA = Australian Health Practitioner Regulation Authority, ANMAC = Australian Nursing and Midwifery Accreditation Council, EPIQ = Gradate Certificate in Australian Nursing, IELTS = International English Language Testing System, IRON = Initial Registration for Overseas Nurses, NMBA = Nursing and Midwifery Board of Australia, OET = Occupational English Test, RN = Registered nurse.
Source: Authors.

2.5. Characteristics of India-trained Nurses in Australia

Table 3.2 shows a brief profile of four survey participants, three from Kerala and one from Karnataka, southern India. Kerala has traditionally been a major source of nurses. In the Greater Melbourne area, about 60% of India-trained nurses migrated from Kerala and are mostly

Christian.[5] The four were registered nurses in India. Except for Nurse 3, who had completed a diploma in nursing, the nurses have a BSc in nursing. Nurse 3 had to take undergraduate courses in nursing in Australia and spent a longer period in a bridging programme to become a registered nurse. The others went through 3-month bridging courses, either in Australia or New Zealand. Nursing certifications in New Zealand are easily transferrable to Australia under the Trans-Tasman MRA.

The cost of migration is high for those who take bridging courses in Australia, about INR1.1 million or US$14,000, more than half spent on course fees. For example, the fee for an IRON course starts from AUD12,000 or US$7,500. The cost of migration is financed by nurses' own savings, a bank loan,[6] or support from the spouse's family. India-trained nurses migrating to Australia seem to have access to financial resources and are generally from well-off families.

The husbands of two nurses did not have full-time jobs; they worked part-time or as temporary workers, a situation observed amongst interviewed nurses from India living in New Zealand or the US (George, 2005). The husbands worked full-time before coming to Australia, but when their wives migrated, they followed. Typically, wives migrated first, then husbands arrived later on spouse visas after their wives completed their bridging programmes, registered as nurses, and found employment. The husbands faced difficulties finding jobs without any qualifications recognised in Australia. They worked part-time or full-time but not in the fields or jobs they enjoyed working in before coming to Australia. In some cases, they became 'househusbands', taking care of household duties and driving their children to school.

For the husbands' families, arranging marriages between their sons and migrating nurses provides them with access to a developed country. The husbands' families are happy to pay the fees for the bridging course that nurses (such as Nurse 4) must take to become registered. One study argued that the possible opportunity of overseas migration gave nurses a higher value in the marriage market (Percot and Irudaya Rajan, 2007).

[5] According to the 2016 Census, there are 3,312 nurses in the Greater Melbourne area who speak an Indian language other than English at home: Malayalam (1,919, 57.9%), Punjabi (597, 18.0%), Hindi (422, 12.7%), Tamil (218, 6.6%), and other languages (156, 4.7%).

[6] Indian banks issue loans to nurses to pay for a bridging course. Indian nurses who took out such loans said banks were willing to lend money to migrating nurses.

Table 3.2. Brief Profiles and Characteristics of Sampled Nurses

All nurses are RN

	Nurse #1	Nurse #2	Nurse #3	Nurse #4
Type of Workplace	Public hospital	Public hospital	Public hospital	Public hospital
State of origin in India	Kerala	Kerala	Karnataka	Kerala
Religion	Christian	Christian	Christian	Christian
Gender	Male	Female	Female	Female
Degree	BSc	BSc	Diploma	BSc
Marital status	Married	Married	Married	Married
Spouse's work (full/part time)	Part-time	Part-time	Full	Part-time
Previous migraiton	None	Dubai, NZ	None	None
Nurses in family	Yes	No	No	Yes
If yes above, Is s/he abroad?	Yes	No	No	n/a
Is Australia the first choice?	No (US)	No	No (parents migration)	Yes
Bridging course	Yes-3months	No (Did it in NZ)	Yes-6months/Undergrad nursing	Yes-3monts
Cost of migration	INR 1million	AUD 5000	n/a	INR 1.1million
Financing migration	Own saving and Bank	Own saving	N/A	Parents in Law
Use of Recruitment Agent	Yes	No	No	Yes
VISA type when arrived	Tourist	Skilled Permanent (Ind)	Family visa	Student visa
Advantages	Salary,	Employment, Job satisfaction	Job flexible	Career development, flexible hours
Disadvantages	Stress, Workload, bullying	Discrimination	Bullying, Exclusion	Stress, high physical involvement

AUD = Australian dollars, BSc = Bachelor of Science, INR = Indian rupees, NZ = New Zealand.
Source: Authors.

3. New Zealand

3.1. Overview of Foreign-trained Nurses

In New Zealand, demand for nurses has been increasing. One main reason is the ageing population. The proportion of those aged 65 plus was 9.9% in 1981, 14.3% in 2013, and projected to be 26.7% by 2063 (Statistics New Zealand, 2015). The population grew by 14.5% between 2011 and 2019, higher than the 11.4% between 1991 and 2001, and 12.3% between 2001 and 2011 (Statistics New Zealand, 2020), because more migrants had entered the country. It is predicted that 25,000 more nurses will be required by 2030 (Hancock, 2019). The supply of home-grown nurses does not meet growing demand, mainly for three reasons.[7] Firstly, the number of local nursing students is not enough. The number of new graduates who passed the Nursing Council's state exam increased from 1,321 in 2010 to 1,817 in 2013 (Ministry of Health, 2014). However, the entire new potential workforce neither gains employment nor stays in the country. Secondly, the workforce is decreasing and ageing. The Ministry of Health (2016) reported that the average age of nurses is 46.3 years, and 45.2% of nurses are over 50. A large part of the present workforce will reach retirement age within the next 10–15 years (Clendon and Walker, 2012: 4). Thirdly, because of the Trans-Tasman MRA, more nurses migrate from New Zealand to Australia than the other way around. In 2017, there were 652 Australian nurses in

[7] New Zealanders work up to 40 hours per week. Nurses can decide how many hours per week they work, which may contribute to the nurse shortage.

New Zealand and 6,847 New Zealand nurses in Australia (Tables 3.1 and 3.3). All these factors lead to recruitment of more nurses from overseas.

The Ministry of Health (2014: 2–3) reports: 'Locally trained doctors and nurses are leaving to work overseas, and there is a heavy reliance on highly mobile locums and overseas-trained health professionals to fill the vacancies'. New overseas registrations nearly equal or exceed the number of new home-trained registrations every year (Walker and Clendon, 2015). Some schemes have been introduced to resolve, in the medium to long term, recruitment, retention, and distribution issues of home-grown nurses. For example, the Voluntary Bonding Scheme encourages nurses to work in difficult places and specialties so they can earn as much as they can to pay off student loans. The Advanced Trainee Fellowship Scheme enables nurses to undertake advanced training or study in New Zealand or overseas in a shortage-specialty area. Whilst 2,413 nurses had used the Voluntary Bond Scheme as of 2014, only one had used the Advanced Trainee Fellowship Scheme (Ministry of Health, 2014)

Immigration policy has clearly tackled the shortage of registered nurses and placed registered nurses in skill-shortage lists. Although the categories or names of the lists have changed, a wide range of registered nurses, including those who are specialised in mental health; aged care; clinical care; and emergency, medical, and perioperative care have been listed as priority occupations for immigrants from the early 2000s (North, 2007) to February 2017. All registered nurse categories were removed in 2017.[8] The Long-term Skill Shortage List (New Zealand Immigration, 2019)[9] and Regional Skill Shortage List include registered nurses (aged care) because the aged care association lobbied to add them (Jackson, 2019).

Nurses, if their occupation is in the skill shortage list, can gain bonus points to obtain various visas, including reside to work, work visa, resident visa, and others. Employers need not go through the formal labour recruitment to prove that they cannot find a local person for the job. Even if registered nurses are not listed in the skill shortage category, employers may hire foreign-trained nurses.

Table 3.3 shows that the number of foreign-trained nurses increased from 8,931 in 2008 to 13,115 in 2018. The countries of origin changed during this period. In 2008, 4,169 (46.7%) foreign-trained nurses came from the UK, followed by 672 (7.5%) from Australia, and 645 (7.2%) from South Africa. In 2018, 4,282 (32.6%) were from the Philippines, followed by 3,380 (25.8%) from the UK and 2,369 (18.1%) from India. Clearly, more foreign-trained nurses are recruited from Asian countries, especially the Philippines and India.

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[8] The New Zealand Nurses Organization (NZNO), the largest nurse labour union and professional organisation for nurses, midwives, and caregivers, along with other national nursing organisations, recommended that all nursing categories be removed from the list (NZNO, 2017). They said that long-term health-work planning is required rather than reliance on recruitment of nurses from overseas (NZNO, 2017).

[9] The list, generally reviewed every 6 months, identifies occupations that have a sustained and ongoing shortage of highly skilled workers, globally and throughout New Zealand.

Table 3.3: Foreign-trained Nurses and Country of Origin in New Zealand

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Australia	672	648	657	740	675	639	636	652	698	652	698
China	71	70	118	125	130	134	143	99	145	142	147
Fiji	-	-	-	452	441	436	424	421	434	409	402
India	563	666	882	1200	1457	1526	1697	2076	2373	2330	2369
Philippines	-	-	-	1694	2009	2234	2498	2975	3684	3924	4282
South Africa	645	672	695	712	649	656	627	607	595	558	571
United Kingdom	4169	4301	4303	4036	3925	3831	3759	3695	3545	3415	3380
Total	8931	9298	10115	10532	10764	10885	11170	11972	12894	12680	13115

Source: Organisation for Economic Co-operation and Development.

3.2. Characteristics of Asian Nurses

Asian, including Indian, nurses have three main characteristics. Firstly, foreign-trained nurses are significantly younger than home-trained nurses (Walker and Clendon, 2015; Nursing Council of New Zealand, 2020). Age is related to willingness to work abroad and immigration policies in receiving countries. Younger nurses from India tend to be more likely to go abroad (Oda, Tsujita, and Irudaya Rajan, 2018). In New Zealand, the younger the nurses are, the more points they earn to work, reside, and achieve permanent residency. Secondly, foreign-trained nurses concentrate in Auckland, where 36.7% of the overall nursing workforce is foreign trained, a far higher proportion than in other regions (the national average is 26.6%) (Nursing Council of New Zealand, 2020).[10] Thirdly, Asia-trained migrant nurses tend to work in aged care (Walker and Clendon, 2015; Nursing Council of New Zealand, 2020). In New Zealand, aged care services are largely privatised, whilst the district health boards, which are fully funded by the government, mainly provide health and medical services. Nurses in aged care are paid much less, NZD5 per hour, than those working in the public sector (Wallance, 2019), which is why home-trained nurses prefer not to work in the aged care sector.

3.3. Pathway to Become a Registered Nurse

In New Zealand, those who complete a 3-year BSc programme leading to registration as a nurse are required to sit and pass the Nursing Council State final examination. In the case of foreign-trained nurses (New Zealand Nursing Council, undated), the process of registration is different for those registered in Australia and those registered in other countries. Those registered in Australia are registered in New Zealand through the Trans-Tasman MRA, but those registered in other countries are required to send documents to the Credentials Verification Services for the Nursing Council of New Zealand (CVS-NCNZ) at Comission on Grants of Foreign Nursing Schools (CGFNS) International Inc. The documents include IDs, employment history, nursing education history, license validation, and language proficiency.[11] Once CGFNS completes the verification process, the Nursing Council decides on each registration. Foreign-trained nurses from Asian countries are often required to take a bridging course called the Competency Assessment Programme (CAP).

The CAP, stipulated by the Health Practitioners Competence Assurance Act 2003, is a bridging course for foreign-trained nurses and for local nurses who have been away from practice for more than 5 years. The CAP is provided by the Nursing Council's accredited providers, 20 institutions as of July 2019. The course consists of theory and clinical practice over 5–12 weeks (Table 3.4), during which the candidates are continuously assessed and can be dropped out. Those who complete the CAP successfully are officially recognised as registered nurses.

[10] The government discourages foreign-trained nurses from working in Auckland. Our interviews with Indian migrant nurses found that those who work outside Auckland can earn higher points to obtain permanent residency and those who take a nursing bridge course outside Auckland are given a longer post-study visa.

[11] Language proficiency is waived for those who registered in the UK, Ireland, Canada, and the US.

Institutions admit more international than local students, partly because international students pay much higher fees than local nurses, and partly because demand for international students is higher than for local nurses who have been away from nursing. Admission to the CAP is highly competitive for international students, and we came across Indian migrant nurses studying nursing in a 1-year graduate diploma course in combination with the CAP, as the validity of the English proficiency test expires if they wait to be admitted to the short-term CAP course.

Table 3.4: Competency Assessment Programmes

	Length	Basic fees for International students (NZD)	Basic fees for Domestic students (NZD)
1	9 weeks (full-time)	6,720	1,530-1,940
2	First 3 weeks for theory and following 5 weeks (200 hours) for clinical practice	10,000	10,000
3	Not applicable	NA	NA
4	Full-time 7 weeks (2 weeks theory and 5 weeks clinical placement)	8,000	2,400
5	2 weeks in school and 6 weeks in clinical placement.	11,550	NA
6	Full-time (2 weeks theory and 6 weeks clinical)	10,000 (approx.)	2,000 (approx.)
7	12 weeks (150 total student learning hours, maximum of 300 clinical practice hours)	9,750+	2,382
8	Minimum 8 weeks	Price on application	1,991
9	6 weeks training, with 10 classroom days and 20 clinical duties at private hospital sites	8,250+	7,800+
10	Full-time 5–8 weeks (Face-to-face and online learning, 10 days of theoretical skill-based study, plus a minimum of 120 hours clinical practice)	9,035	1,663 (with ID); 1,648 (without ID)
11	6 weeks: Classroom-based teaching (theory and written assessments for 60 hours and clinical placement for 4 weeks (20 clinical shifts, 160 hours)	10,500	10,500
12	7 weeks	8,700	NA
13	Not applicable	NA	NA
14	Full-time (12 weeks)	8,900	1,845
15	Full-time (12 weeks)	10,000	2,418
16	Lecture format (first 5–6 weeks part-time) and clinical placement	9,180	1,838

17	Full-time (6–12 weeks)	NA	2,500
18	Complete within 8–12 weeks of the start date	NA	NA
19	9 weeks	15,000	2,500
20	8 weeks	NA	3,007

Source: New Zealand Nursing Council (2019).

3.4. Indian Migrant Nurses

Why do Indian migrant nurses prefer New Zealand? Mainly, according to our interviews, because it allows foreign-trained nurses to combine all the English test scores taken over 12 months. The current requirement to apply for nursing registration is a minimum score of 7.0 in the International English Language Testing System (ILETS) and B in the OET for every band: reading, listening, writing, and speaking. If a candidate cannot achieve the minimum score in any band in either the ILETS or OET sitting, they can take the exam until they fulfil the requirement for the next 12 months. Such flexibility was not found in other English-speaking countries such as Australia, the UK, and Ireland until recently. Only one nurse, whose husband was working in New Zealand, was decisive about New Zealand as her preferred migration destination. Otherwise, 12 of the sampled nurses came to New Zealand mainly because of their English proficiency score. For example, 'I would like to go to Australia but could not obtain the minimum score in one test, so I came to New Zealand' (New Zealand participant 4). Similarly, 'My English score only matched the New Zealand requirements when I investigated the requirement of the other English-speaking countries' (New Zealand participant 13). Most of the nurses said Australia was their first preferred destination before arriving in New Zealand. Another example was a nurse we interviewed who took a bridge course in Melbourne, Australia, because her relatives lived there. But she could not find a job there, which is why she came to New Zealand.

We found from interviews that the cost of migrating to New Zealand, except for English tests, is high, INR800,000–INR1,000,000 (US$10,800–US$13,500). Those migrating to Australia pay about that much, which is at least 10 times more expensive than the cost of migration to the Gulf countries from India, as per our previous survey. Most of the sampled nurses earned several thousand Indian rupees monthly in private hospitals in India before they arrived in New Zealand. They had to finance the cost of migration somehow and seem to come from well-off families.

Some of the sampled nurses had worked in other countries such as Saudi Arabia, Qatar, or Ireland and could finance the cost of migrating to New Zealand on their own. The rest of the sampled nurses, however, had to borrow money either as an education loan under their own name, or other loans from their father, husband, or father-in-law. Going to New Zealand as a nurse is a once-in-a-lifetime opportunity that benefits the entire family. Thus, it is the household's strategy and the reason it can be financed by the in-laws. Except for one nurse, whose husband was working in New Zealand, the other 11 married nurses (1 was divorced) came to New Zealand alone. Their spouses (and children) joined from India or from the first migration destination country.

New Zealand reportedly has a high turnover of foreign-trained nurses, particularly because they can move directly to Australia once they register under the MRA (Walker, 2008; New Zealand Nurse Organization, 2018). Asked if they intended to migrate to Australia or elsewhere, the nurses gave mixed answers. Those thinking of going to Australia said: 'A lot of friends have already left for Australia. In Australia, nurses are better paid, the cost of living is lower than here. In particular, the rent is very expensive here, and the houses are smaller than those in Australia' (New Zealand participant 7). 'It is not only better paid in Australia but also closer to India, and more flight options are available. We cannot go home easily from here in case of an emergency

back home' (New Zealand participant 10). Importantly, 3 out of 14 of the sampled nurses in Australia had formerly worked in New Zealand. One said, 'My husband is educated but could not find a job in Auckland. That is the main reason why we came to Australia' (Australia participant 5). Many of the nurses' husbands seemed to be engaged in unskilled jobs or were self-employed, as finding a reasonably good job is not easy in New Zealand. Some nurses confessed that they were professionally satisfied in a smaller town's public hospital in New Zealand, but because of job opportunities for the husband, they came to Christchurch, a larger town (New Zealand participants 4, 12, and 13).

Some nurses were willing to stay in New Zealand. One told us: 'A lot of friends left for Australia, and they told us to come. However, I am not interested in going there now. I heard that racial discrimination is more severe in Australia than here' (New Zealand participant 3). 'We have settled down and our children go to school here. Besides that, I heard there are a lot of snakes in Australia. There are no snakes in New Zealand' (New Zealand participant 5).[12] Whether or not the sampled nurses were willing to move to Australia, their decision was based not only on economic reasons but also on household and personal ones.

The nurse-receiving countries ease the qualification standards for foreign-trained nurses when they suffer from a shortage of nurses, whilst they tighten requirements when they have enough nurses. Work experience, language proficiency, and educational background are common criteria that nurse-receiving countries adjust from time to time. New Zealand changes the standard qualifications for registered nurses from abroad from time to time, as well. Some India-trained migrant nurses cannot meet the educational criteria set by the Nursing Council. New Zealand used to allow graduates of India's 3-year nursing diploma to register but now requires a BSc nursing degree. New Zealand participant 7 said: 'Since my brother settled in Australia, I was planning to go there but it was difficult to find a nursing job in 2012. So I came to New Zealand without knowing that India's nursing diploma qualification was not qualified to join the CAP course. I ended up doing a BSc in nursing in this country'.

Although it is outside the scope of this chapter, we came across some caregivers in New Zealand who had completed a diploma in nursing and had a nursing license in India. They did not know that their educational qualification did not meet the minimum criteria to become a registered nurse in New Zealand. They came to New Zealand to study any health-related course. The sampled Indian nurses used an agent in India and/or an Indian agent in New Zealand, because immigration processes are complicated and may change at any time, and because they were busy working in India. The caregivers told us that the recruitment agent in India did not inform them of the minimum requirements to become a registered nurse, and they were optimistic about becoming registered nurses in the destination country. They are struggling to find a way to become registered nurses.

[12] In India, a snakebite is still fatal. The World Health Organization estimated that India sees 2.8 million snake bites and 50,000 deaths a year (Ray, 2019).

4. Conclusions

This chapter demonstrates how foreign-trained nurses, with a focus on India-trained migrant nurses, became registered nurses in Australia and New Zealand. It shows issues and problems from the migrant nurses' point of view, based on our semi-structured interviews with them.

In both countries, the percentage of foreign-trained nurses is on the rise because of the shortage of nursing professionals and the growing ageing population. For foreign nurses to migrate to Australia or New Zealand and practice nursing, they must be registered with the county's nursing board. For Indian migrant nurses, the first hurdle is that they need to meet the requirements, particularly English proficiency. The second hurdle is to complete a nursing board–approved bridging programme.

For Indian nurses, the application and assessment are more complicated in Australia than in New Zealand. Both countries can change the assessment system as well as immigration system at any time, which is one reason why foreign-trained nurses rely on recruitment agents, which raises the cost of migration. Families sending nurses to either country are well-off. It is a household strategy to send a nurse to those countries. Once the sampled nurses became registered, they sent for their families. Marrying a man off to a migrating nurse is a strategy for the man's family to have access to developed countries. Finding a reasonably good job, however, is not easy for the spouse, particularly in New Zealand.

The overwhelming majority of the sampled nurses chose New Zealand because their English score met the specified requirements. Some foreign-trained nurses regard New Zealand as a steppingstone to Australia. The MRA is a double-edged sword; through it, New Zealand attracts those who would like to go to Australia and who might leave for Australia after some time. This implies that the ASEAN MRA on nursing services, which allows registered or licensed nurses to practice nursing in host countries, might have the same consequences. ASEAN nurses might aim to work in a country that offers better pay, more training opportunities, and a higher standard of living. In the European Union, where the health workforce has freedom of mobility, wealthier member states receive more benefits from health workforce mobility at the expense of less wealthy ones (Ginos, 2015). ASEAN may need to adopt the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel.

An implication for India is that the 3-year diploma course is no longer accepted for working in Australia, New Zealand, and some other nurse-receiving countries. Those who would like to go abroad should know about the requirements in overseas labour markets. Governments should provide information on the overseas labour markets and regulate domestic recruitment agents.

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Appendix:

Table 3A.1. Skilled Occupations for Midwifery and Nursing Professionals

(Australian Standard Classification of Occupations: Minor Group 254/Midwifery and Nursing Professionals of Sub-Major Group 25/Health Professionals in Major Group 2/ Professionals)

Occupation	Code	List	Visa subclasses (streams or type)	Assessing Authority
Enrolled Nurse	411411	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Midwife	254111	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Nurse Educator	254211	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nurse Manager	254311	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nurse Practitioner	254411	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Nurse Researcher	254212	STSOL	190, 407, 489 (S/T), TSS (S)	ANMAC
Nursing Clinical Director	134212	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Aged Care)	254412	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Child and Family Health)	254413	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Community Health)	254414	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Critical Care and Emergency)	254415	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Developmental Disability)	254416	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Disability and Rehabilitation)	254417	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Medical Practice)	254421	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Medical)	254418	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Mental Health)	254422	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Paediatrics)	254425	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Perioperative)	254423	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurse (Surgical)	254424	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC
Registered Nurses nec	254499	MLTSSL	186, 189 (PT), 190, 407, 485 (GW),489 (F), 489 (S/T), TSS (M)	ANMAC

ANMAC = Australia Nursing and Midwifery Accreditation Council, F=Family nominated, GW=Graduate Work, M=MLTSSL = Medium and Long-term Strategic Skills List, PT=Point-tested, S/T=State or Territory nominated, TSS=Temporary Skill Shortage.

Source: Government of Australia, Department of Home Affairs (

Chapter 4

Human Resource Development, Employment, and Awareness of Nurses in Viet Nam of Working Abroad

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Nguyen Ngoc Toai

1. Introduction

In recent decades, international migration of nurses and caregivers has increased rapidly as demand for them in developed countries increases because of ageing populations, the shift from family care to institutional care for the elderly, and health tourism, amongst others. Demand is higher for professional quality than quantity. Although the number of nurses migrating from developing countries, most notably from India and the Philippines, to Organisation for Economic Co-operation and Development countries has increased rapidly, the shortage of nurses remains high (Dumont and Lafortune, 2017).

Over the past decades, Viet Nam's government has issued healthcare policies to meet the country's Sustainable Development Goals in the context of the ageing population and deeper international integration. The government has signed agreements with Association of Southeast Asian Nations (ASEAN) countries (ASEAN, 2006) and developed countries such as Japan (Ministry of Foreign Affairs of Japan (2008); Embassy of Japan in Viet Nam) and Germany (Ministry of Labor, War Invalids and Social Affairs [MOLISA], 2019) to improve capacity, standardise training quality, and send nurses to work abroad.

Although nursing universities and colleges in Viet Nam have increased rapidly over the past 2 decades, the nurse workforce has yet to meet national and international needs. The extent of the gap between supply and demand, and the professional development of nurses needed to meet demand must be explored. This report provides an overview of Viet Nam's nurse workforce, including its human resource development, career development, nurses' intent to migrate internationally associated to their socio-demographic and professional characteristics, and possible impact and policy implication of such migration on the health sector in Viet Nam.

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2. Data Sources and Research Methods

The study is based on data from sample survey questionnaires, analysis of secondary documents, and in-depth interviews with experts in nursing education and management in Ho Chi Minh City (HCMC).

The survey was carried out by the research team of the Southern Institute of Social Sciences, mainly from July to October 2020. Some of the 200 interviews were conducted later because of practical difficulties of finding nurses who met the interview criteria, and the prolonged effects of the coronavirus disease (COVID-19) pandemic in HCMC.

Initially, the research aimed to survey at least 200 alumni of more than three nursing institutions, excluding those who had completed their nursing studies since 2018. To increase the sample representation, the research team applied a vertically stratified sampling method for health facilities (central, city, district) and a horizontally stratified one (public, non-public). The research team then interviewed nursing staff who met the study's criteria.

However, the research team found that only a small number of nurses had graduated from college or university and were working at local health facilities, and that many were not working in nursing care but were doing administrative or other jobs. Most of the nurses in nursing care had only intermediate qualifications (defined in section 3), especially those at district health facilities and non-public health facilities. Many had graduated from college or university only since 2018 or were in a college or university programme but had not graduated yet.

Before Circular No. 26/2015/TTLT-BYT-BNV (Ministry of Health [MOH] and Ministry of Home Affairs [MOHA], 2015), only intermediate qualifications were required for nursing care. The circular requires that from 1 January 2021, public employees recruited for the initial professional title of grade IV nurse must have a college degree in nursing. Public employees with intermediate qualifications who were recruited and appointed to this professional title before the said date must obtain a college degree in the right major before 1 January 2025. Non-public health facilities, however, can refer to but are not governed by the circular and can still hire nurses with intermediate qualifications so as not to increase salary costs.

The situation made it impossible for the research team to find enough nurses who met the initial criteria. Thus, the team had to expand the survey population to nurses with less than 3 years of nursing education and to large hospitals around HCMC, mainly in Bien Hoa city (Dong Nai province), about 30 kilometres from central HCMC.

The COVID-19 pandemic and the prolonged blockade in HCMC made it difficult to access health facilities and nursing staff. Because nurses were busy with stressful epidemic-prevention activities, and COVID-19 prevention regulations at health facilities were strict, most of the survey questionnaires were sent to be filled in by the nurses and later collected by the research team. Besides distributing paper questionnaires, the research team conducted online interviews with 39 of 200 respondents.

Secondary statistics on the nurse workforce were synthesised from the health statistical year books of MOH. Although incomplete, nurse workforce data provided some statistical indicators related to the number, professional qualifications, and distribution of nurses by type of health facilities over time.

Viet Nam has two specialised journals on nursing: *Journal of Nursing Science,* managed by Nam Dinh University of Nursing, a specialised nursing training institution established in 1960; and *Vietnam*

Nursing Journal, managed by the Viet Nam Nursing Association. The research team reviewed a number of articles related to the research topic from the journals.

The analytical method used was mainly based on descriptive statistics and binary logistics models. The variables measuring the degree of relevance to the respondents' assessments were based on a 4-point Likert scale, where 1 = very irrelevant, 2 = irrelevant, 3 = relevant, and 4 = very relevant. Because of the small sample size, to increase the number of observations in the groups and the validity of the model, the independent variables were recoded into binary variables. Categories (1) and (2) were grouped into 'not relevant' and categories (3) and (4) into 'relevant'. Binary logistics models were used to evaluate the influence of socio-demographic and occupational factors on nurses' intention to work abroad. The results of in-depth interviews contributed to the interpretation of the findings from the quantitative analysis.

3. Human Resource Development of Nurse Workforce in Viet Nam

3.1. Human Resource Development of Nurse Workforce from a Macro Perspective

The nursing training system in Viet Nam has four professional qualifications: elementary: 3–12 months; intermediate: 2 years; college: 3 years; and university: 4 years. Continuous learning allows nurses with lower degrees to participate in higher training programmes, such as from intermediate to college or from college to university, to meet the requirements of higher professional qualifications.

In 2020, Viet Nam had 185 training institutions on human health resources, including nursing, at intermediate, college, and university levels. Nursing was taught at 35 university training institutions and 83 college training institutions nationwide, of which public institutions accounted for 40% and 56.63%, respectively (MOH, 2020b).

Table 4.1 shows that the number of nurses in Viet Nam increased by about 40% and the ratio of nurses to population increased by about 24% from 2009 to 2020. In the same period, the proportion of nurses with university qualifications increased from 3.6% to 15.9% whilst the proportion of nurses with elementary qualifications decreased from 10.9% to only 0.5% of the total number of nurses.

Nurses with college and intermediate degrees accounted for about 85% of all nurses, and hardly changed over time despite constant internal movement caused by the addition of newly graduated nurses, the internal shift of nurses studying continuously from the intermediate level to college, and the exit of nurses from this group after continuing education and graduating from universities. Women make up most of those who study and work in nursing care and about 90% of the total number of nurses (MOH, 2018).

Table 4.1: Nurses in Viet Nam by Professional Qualification

Year	Total number of nurses (n)	of which (%)			No. of nurses per 10,000 inhabitants (n)
		Nurses graduated from university	Nurses graduated from college and intermediate school	Nurses graduated from elementary school	
2009	75,891	3.6	85.5	10.9	8.8
2010	81,248	4.6	86.6	8.8	9.4
2011	88,019	5.7	87.2	7.1	10.0
2012	92,201	6.6	87.1	6.3	10.4
2013	96,689	8.3	86.2	5.5	10.7
2014	97,790	9.6	85.7	4.7	10.8
2015	101,386	10.6	85.5	3.9	11.1
2016	104,483	11.9	84.8	3.3	11.3
2017	106,099	13.9	83.4	2.7	11.3
2018	108,113	15.7	82.2	2.1	11.4
2019	106,346	16.0	83.6	0.5	11.0
2020	106,361	15.9	83.6	0.5	10.9

Sources: Ministry of Health (2013, 2016, 2018, 2020a).

Before 2000, 85% of the nurse workforce in Viet Nam had an intermediate degree, 10% had an elementary degree, less than 5% had a college degree, and a few had a university degree (Phạm Đức Mục, 2020). However, by 2020, 16,963 nurses had a university degree. Nurses who graduated with a university degree were 3,346 in 2016, 3,472 in 2017, and 3,589 in 2018 (MOH, 2016, 2017, 2018), including those who had previously graduated with a college degree. The number of nurses who graduated from university in 2016–2018 accounted for about 60% of all nursing university graduates.

Although no official data are found on the percentage of nurses with a college degree in the group of nurses with intermediate and college degrees, the number of nurses with an intermediate degree may be proportionally high because the number of people graduating from nursing colleges in recent years is still limited. Circular No. 26/2015/TTLT-BYT-BNV (MOH and MOHA, 2015), stipulating the qualifications of nurses for public employment from 1 January 2021 and a standardised road map by 1 January 2025 for nurses recruited before 1 January 2021, has forced nurses with an intermediate degree who are working in public health facilities to continue their education to college level. In 2020, nursing university enrolment was 5,780 and college enrolment was 15,900 nationwide (MOH, 2020a), showing that training of highly qualified nursing personnel has increased rapidly in recent years.

Non-public and multidisciplinary training institutions have increased significantly to meet market demand. Colleges have been established and many former vocational colleges have changed their names and participated in health training programmes. Many training institutions have joined others with relevant functions or have opened branches in other localities, creating a diverse training network nationwide. The number of intermediate schools has fallen sharply because of mergers with community colleges. Others were dissolved because of a sharp decrease in demand for elementary nursing training.

The Vietnam Nursing Association (VNA) is important in developing nurses and nursing care policies. Established in 1990, VNA has developed a nationwide system of organisations and actively participated in many policy advocacy activities, training programme development, publishing, and dissemination of nursing knowledge (Phạm Đức Mục, 2020).

To ensure the quality of training, MOH (2012) issued a set of professional competency standards for nursing, including training in (i) practical capacity, (ii) care management and professional development, and (iii) law and professional ethics, divided into 25 standards and 110 indicators. The structure and content of the professional competency standard show that professional nursing standards in Viet Nam are compatible with nursing in Asia and the Pacific and ASEAN, reflecting regional integration efforts and the internationalisation of Viet Nam's nursing industry.

Regarding the output standards, Circular No. 54/2018/TT-BLDTBXH stipulates the minimum amount of knowledge and competency requirements that nurses must achieve upon graduating from college or earning an intermediate degree in nursing (MOLISA, 2018). However, the output standard is still general and MOH (2012) has not linked it to the professional competency standard. As of 2020, Viet Nam had no specific standards and criteria in accrediting nursing institutions (MOH, 2020b). As of 2019, nursing training institutions lacked lecturers and experts in nursing science, so nearly 70% of nursing teaching staff were medical doctors (Aungsuroch et al., 2019).

The capacity of training institutions in nursing has yet to meet the nurse workforce requirements per policy objectives. Resolution No. 20/NQ-TU of the Communist Party of Vietnam (2017) on strengthening the protection, care, and improvement of people's health states that there should be 25 nurses per 10,000 inhabitants by 2025 and 33 nurses per 10,000 inhabitants by 2030. Decision No. 2992/QD-BYT of MOH (2015) on human resource planning in the medical examination and treatment system had forecast that demand for nurses by 2020 would be about 225,000, or 84,000 more. MOH (2022) reported that the whole country needs 304,200 nurses in 2021–2030 and 1.2 million nurses in 2031–2050.

Compared with the statistics (Table 4.1), the number of nurses per 10,000 inhabitants has increased only from 8.8 to 10.9 after more than 10 years, with only 5–10 years left to reach the target of 25 and 33 nurses per 10,000 inhabitants by 2025 and 2030, respectively, as set in Resolution No. 20/NQ-TU. The number of nursing staff increased from about 76,000 in 2009 to about 106,000 in 2020 or only about 50% of MOH's target (2015).

3.2. Human Resource Development of Nurse Workforce from a Micro Perspective

This section presents results from our sample survey. Table 4.2 presents the socio-demographic characteristics of nurses; most (71.3%) were 35 years old and under, the age when they are recruited for overseas work. Men made up a small proportion (15%), close to the gender structure of nursing profession at that time.

Nearly 40% of respondents were single; the rest were either married, widowed, or divorced. A fairly high percentage (37%) of nurses had family members or relatives working as nurses. However, only 5% (10) had family members or relatives working as nurses abroad. Different socio-demographic characteristics might have different relationships to the motivations and professional activities of the nurses. However, whether or not family members or relatives were working abroad as nurses might have little influence on the decision of those who were interviewed to work as nurses abroad.

Table 4.2: Socio-demographic Characteristics of Nurses

	n	%
Age	174	100.0
23–35	124	71.3
Above 35	50	28.7
Gender	200	100.0
Men	30	15.0
Women	170	85.0
Marital status	200	100.0
Single	77	38.5
Married	123	61.5
Member of family/relative is a nurse	200	100.0
Family/Relatives	74	37.0
No	126	63.0
Member of family/relative is a nurse abroad	200	100.0
Family/Relatives	10	5.0
No	190	95.0

Source: Authors.

Table 4.3 shows that most interviewees had just graduated from nursing colleges and universities. Those who graduated in 2014 or earlier accounted for 41%; those who graduated in 2015,[†] 2016, and 2017 for 30%; and those who graduated since 2018 for 29%. In addition to improving capacity to meet the requirements of ASEAN and international integration, Circular No. 26's binding regulations on qualifications for recruitment and standardisation requirements associated with job positions and salaries in the public sector have been important in supporting more participation in training programmes at colleges and universities in recent years.

Because of increasing demand for nurses, public institutions with a long medical tradition such as HCMC University of Medicine and Pharmacy and Pham Ngoc Thach Medical University, and non-public universities such as Hong Bang University and Nguyen Tat Thanh University have opened undergraduate programmes. Other institutions such as Tra Vinh University, Hanoi Medical University, Hue Medical University, Military Medical Academy, University of Public Health, and others have undergraduate programmes in HCMC. HCMC has many colleges, mainly non-public, that offer 3-year nursing programmes.

Table 4.3 indicates that 62% of respondents graduated from universities and 53.5% from public institutions. Most of them studied in HCMC because of the many universities and colleges there; a few graduated from institutions elsewhere.

[†] When Circular No. 26 (MOH and MOHA, 2015) was issued.

Table 4.3: Training Profile of Nurses

	n	%
Nursing graduation year	200	100.0
2014 and earlier	82	41.0
2015–2017	60	30.0
2018–2020	58	29.0
Nursing programme level	200	100.0
University (4 years)	124	62.0
College (3 years)	76	38.0
Name of university/college	198	100.0
Hong Bang University	48	24.0
HCMC University of Medicine and Pharmacy	47	23.5
Nguyen Tat Thanh University	29	14.5
Tra Vinh University	11	5.5
Other universities/colleges	63	31.5
Ownership of university/college	200	100.0
Public	107	53.5
Private	93	46.5
Place of nursing education	200	100.0
Ho Chi Minh City	155	77.5
Dong Nai province	9	4.5
Nam Dinh province	7	3.5
Tra Vinh province	6	3.0
Other provinces	22	11.0
Missing	1	0.5
Sources of information about university/college	242	100.0
Family/relatives	53	21.9
Friends/neighbours/acquaintances	53	21.9
Enrolment counselling of universities/colleges	62	25.6
Websites/internet	56	23.1
Teachers at high school	18	7.4
Current highest education level	200	100.0
Graduated from college/university	194	97.0
Studying a master's degree	4	2.0
Graduated a master's degree	2	1.0

Source: Authors.

Regarding the sources of information about nursing institutions, the many choices show that enrolment advertising, websites, and the internet play the most important role, confirming the

advantages of information technology. Networks of family, relatives, and friends, however, are also significant in searching for the most suitable institutions.

Only a few nurses graduated with or were studying for a master's degree in nursing, indicating limitations in training more qualified nurses for research, teaching, and nursing care.

The results show that the nurses themselves (87.5%) decided on their own to study nursing, with insignificant influence from family, relatives, and high school teachers (Table 4.4). The nurses' showed initiative and responsibility, which could advance their career.

Table 4.4: Person Deciding on Nursing Study of Learners

	200	**100.0**
Herself/himself	175	87.5
Father	2	1.0
Mother	11	5.5
Siblings	5	2.5
Relatives	6	3.0
High school teachers	1	0.5

Source: Authors.

To quantify the reasons for choosing a nursing career, the interviewees rated the best fit for themselves across various aspects. Table 4.5 shows the three reasons with the highest mean value for choosing a nursing career: (i) to help patients (3.16 on a scale of 4), (ii) to get a job easily in the domestic market (2.89), and (iii) to support the family (2.56). The three reasons with the smallest mean values were (i) to work abroad (1.62), (ii) to easily find work abroad (1.71), and (iii) to follow the family's wishes (1.72). These choices reflect the professional ethics and the practical view of the interviewees. They wanted to work at domestic health facilities and earn to support their family, not to have a high income and good benefits or to work abroad. The mean values of working abroad were very low, indicating that it was not an option for many nursing students.

Table 4.5: Reasons for Choosing Nursing Career

	Levels: 1 (lowest) to 4 (highest) (%)				n	Mean
	1	2	3	4		
Work abroad	57.5	25.0	15.5	2.0	200	1.62
Easily find domestic jobs	9.5	19.5	43.5	27.5	200	2.89
Easily find jobs abroad	49.0	33.5	15.0	2.5	200	1.71
High salary and benefits	15.0	46.5	32.5	6.0	200	2.30
Support family	13.5	32.0	40.0	14.5	200	2.56
Family wants me to work in nursing	26.5	30.0	31.5	12.0	200	2.29
Have better social status	28.5	36.0	27.5	8.0	200	2.15
Help patients in need	5.5	11.5	45.0	38.0	200	3.16
Follow nursing occupation of family	54.5	25.5	13.5	6.5	200	1.72
Nursing is a respected profession	18.0	34.5	31.5	16.0	200	2.46

Source: Authors.

Financing nursing studies can affect occupational motivation. Table 4.6 shows that 12% of respondents received scholarships or financial support from universities or colleges, health facilities where they are working, and the state, but mostly scholarships from universities or colleges. To support students with good academic standing or students in difficult economic conditions, such as those from poor households, ethnic minority households, poor areas, ethnic minority areas, and others, public and non-public institutions grant scholarships, mainly in the form of tuition fee exemption or reduction. Depending on specific conditions, some health facilities help nurses with advanced professional qualifications from intermediate to college and university meet the requirements of Circular No. 26. The state helps health workers, including nurses, in poor areas and ethnic minority areas attend education institutions to improve their qualifications.

Although such support is helpful, the interviewees reported that the costs of food, accommodation, transportation, and other expenses during their studies were much larger. The main financial sources for their studies were income from their job (42.2%), parents (40.9%), and loans (15.5%). Many nurses studying at colleges and universities are those who had graduated from intermediate school and continue to study at a higher level according to the state's regulations. Others who are not yet employed rely on their parents' support. Viet Nam's Prime Minister (2007) issued Decision No. 157/2007/QD-TTg to lend money to orphaned and poor students to study.

Table 4.6: Financial Sources for Nursing Study

Scholarship or financial support	200	100.0
Yes	24	12.0
No	176	88.0
Sources of scholarship or financial support	24	100.0
School scholarship	21	87.4
Government budget	2	8.4
Health facilities employing them	1	4.2
Financial sources for study	232	100.0
Parents	95	40.9
Loans	36	15.5
Working whilst studying	98	42.2
Relatives	3	1.3

Source: Authors.

4. Career Development of Nurse Workforce in Viet Nam

4.1. Human Resource Development of Nurse Workforce from a Macro Perspective

Public health facilities are divided mainly into two management levels: (i) the central level (top-level research institutes and hospitals managed by MOH) and the local level (hospitals managed by the provincial departments of health); and (ii) institutes and hospitals managed by non-health ministries or their branches, e.g. Ministry of National Defence, Ministry of Public Security, and others. Since the implementation of the reform policy (Đổi Mới), Viet Nam has had private and foreign health facilities, although most are small hospitals and health centres in large cities, serving foreigners or people who can pay the high fees.

Table 4.7 presents the number of nurses in Viet Nam by university or college level and classification of health facilities where they were working in 2013, 2016, and 2020. Most nurses were working in local health facilities. For university graduates, the employment rate at local institutions increased steadily from 85% in 2013 to 93% in 2020, whilst that at central institutions decreased correspondingly.

Table 4.7: Nurses in Viet Nam by Professional Qualification and Health Facility Classification

	2013	2016	2020
Nurses graduated from university			
Total (n)	7,981	12,467	16,963
of which (%)			
Central	13.2	8.5	6.2
Local	85.3	90.6	93.1
Other branches	1.4	0.9	0.7
Nurses graduated from college and intermediate school			
Total (n)	83,369	88,582	88,868
of which (%)			
Central	9.4	8.9	8.9
Local	85.3	86.2	86.2
Other branches	5.2	4.9	4.9

Sources: Ministry of Health (2013, 2016, 2020a).

As of 2020, 86.8% of the nurse workforce was in the public sector and 13.2% in the non-public sector, 90.6% under a provincial department of health, 8.3% managed by the central government, and 1.1% managed by training institutions (MOH, 2020b).

As of 2020, the ratio of nurses per 10,000 inhabitants in Viet Nam was three times lower than in Thailand, four times lower than in Malaysia, and nine times lower than in Japan (Phạm Đức Mục, 2020). The lack of nurses is a disadvantage to patients as they do not receive the best care from nurses and are at increased risk of errors and hospital infections. Many key departments of hospitals are overloaded, with working shifts of up to 24 hours. Based on international recommendations, one nurse should be in charge of fewer than seven patients per working shift. However, in Viet Nam's hospitals, one nurse in charge of 10–15 patients per working shift was common. The ratio of nurses–doctors in Viet Nam was 1.4 (MOH, 2020b), one of the lowest in the world. Similarly, the ratio of nurses–patients was very low, with usually one nurse having to take care of 20–30 patients (Aungsuroch et al., 2019) and work a 12-hour even a 24-hour shift. Inadequate equipment and poor working conditions should be noted. About 70% of nurses held a secondary-level qualification, focusing mainly on medical techniques and being task oriented (Aungsuroch et al., 2019). This raises the issue of quality of healthcare.

4.2. Human Resource Development of Nurse Workforce in Viet Nam from a Micro Perspective

This section presents some issues on the professional development of nurses from our sample survey. Table 4.8 shows that up to 90.5% worked in public health facilities, the rest in private and foreign-invested medical facilities. The health facilities were concentrated mainly in HCMC, a few in Dong Nai and Binh Duong provinces, which are adjacent to HCMC. Although the study tried to sample by type of health facility, few working nurses had college degrees or higher, so the sample structure depended on the actual situation. Central hospitals, in which Cho Ray is the most important in HCMC, have a higher concentration of nurses with nursing degrees from universities or colleges (55.7%), followed by provincial and district health facilities, with the rest accounting for a negligible proportion. As no

specific data on the number of nurses with college and university degrees working in different health facilities are available, the research team found from some health facility leaders that the lower-level health facilities, especially non-public ones not bound by Circular No. 26, usually recruited intermediate nurses for a low salary.

Table 4.8: Characteristics of Current Working Places of Nurses

	n	%
Sector	200	100.0
Public	181	90.5
Non-public	19	9.5
Province	191	100.0
HCMC	162	84.8
Dong Nai	24	12.6
Others	5	2.6
Level of hospital	192	100.0
Central	107	55.7
Provincial	34	17.7
District	29	15.1
Private and foreign	9	4.7
Industrial	4	2.1
Health centres and others	9	4.7

Source: Authors.

In general, the interviewed nurses felt satisfied in their profession. Table 4.9 shows that significantly more women seemed to be more satisfied (3.00) than men (2.77). Married nurses had a slightly higher level of satisfaction (3.00) than single nurses (2.91). However, no significant difference in satisfaction level was found in the remaining socio-demographic characteristics, indicating high homogeneity.

Table 4.9: Feeling Satisfied about Choosing Nursing, by Socio-demographic Characteristic

	n	Mean	SD
Age			
23–35	124	2.99	0.43
Above 35	50	2.92	0.60
Gender			
Men	30	2.77	0.63
Women	170	3.00	0.46
Marital status			
Single	77	2.91	0.40
Marred	123	3.00	0.54
Nursing graduation year			
2014 and earlier	82	2.98	0.521
2015–2017	60	2.92	0.53
2018–2020	58	3.00	0.419
Type of university/college			
Public	107	2.96	0.513
Non-Public	93	2.97	0.477
Nursing programme level	200		
University	124	2.96	0.5
College	76	2.97	0.489
Working place			
Central and provincial hospitals	141	2.96	0.52
Others	51	3.00	0.45
Motivation of finding job abroad			
Yes	35	3.00	0.485
No	165	2.96	0.498
Motivation of high salary and benefits			
Yes	77	3.08	0.532
No	123	2.89	0.458

SD = standard deviation.
Source: Authors.

The research explored the occupational attributes that contributed to the satisfaction level of the interviewees (Table 4.10). Corresponding to the reasons for choosing a nursing career, nurses were most satisfied by being able to help patients who needed them (mean = 3.38 on a maximum scale of 4). The second aspect was relationships with superiors and colleagues (3.00). Aspects that resulted in high satisfaction were self-esteem (2.88) and ease of finding a job (2.87). The opportunity to find job abroad had the lowest mean (2.11). Social status, income and benefits, and working conditions did not provide high levels of satisfaction, reflecting the reality of stressful working conditions.

Table 4.10: Aspects of Career that Contribute to Satisfaction or Dissatisfaction

Aspects of career	Levels: 1 (very unsatisfied) to 4 (very satisfied) (%)				n	Mean
	1	2	3	4		
Help patients	1.0	4.5	50.0	44.4	198	3.38
Social status of nurses	6.6	45.4	42.3	5.6	196	2.47
Possibility of working abroad	27.2	38.5	30.3	4.1	195	2.11
Ease of finding a job	1.5	22.4	63.3	12.8	196	2.87
Self-esteem	3.6	22.8	55.8	17.8	197	2.88
Salary and benefits	3.0	34.5	54.8	7.6	197	2.67
Relationship with superiors and colleagues	1.5	10.7	74.0	13.8	196	3.00
Opportunities for advancement	5.1	27.6	59.7	7.7	196	2.70
Working conditions	7.7	31.8	52.8	7.7	195	2.61

Source: Authors.

5. Factors that Influence Nurses' Intention to Work Abroad

In recent years, cooperative agreements on training and sending nurses abroad have been signed by governments, training institutions, and companies. Since 2012, the Viet Nam–Japan Economic Partnership Agreement has implemented 10 courses and selected and trained 2,012 Vietnamese nurse and caregiver candidates to work in Japan. In 2022, nearly 1,700 nurses were working in hospitals and elderly institutions in Japan (Hồng Kiều, 2022). The project—Triple-win Nurses: Recruiting Vietnamese Students to Become Future Nurses in Germany—started in Viet Nam in mid-2019 as agreed between MOLISA and the Federal Labour Agency of Germany. In 2020, the project selected 230 candidates and provided them a 12-month German-language course (MOLISA, 2019). The two programmes funded 12 months of foreign-language training, airfare, and other related expenses, although the number of selected nurses was limited, showing that Vietnamese nurses do not commonly work abroad.

None of the interviewees was working or had ever worked as a nurse abroad. The percentage of respondents intending to work abroad was only 9.5% (19 people) of the total number of respondents. This number is consistent with the reasons for choosing a nursing career and satisfying career aspects; studying nursing to work abroad or to easily apply for a job abroad has the lowest mean value.

5.1. Factors Influencing Nurses' Intention to Work Abroad

To assess the impacts of socio-demographic and occupational characteristics on nurses' intention to work abroad, we selected independent variables after recoding them into dummy variables (Table 4.11):

i. Age: 35 and under versus over 35. Hypothesis: Those 35 and under had a greater intention to work abroad because they were younger and suitable for training and sending to work abroad.

ii. Gender: men versus women. Hypothesis: Men had a greater intention to work abroad because they were family breadwinners and could more easily adapt to a new living environment abroad.
iii. Marital status: single versus married. Hypothesis: Single people had a greater intention to work abroad because they had fewer family responsibilities than married people.
iv. Graduation year: 2017 and earlier versus 2018 and later. Hypothesis: Those who graduated 2017 and earlier had a greater intention to work abroad because they had more experience and skills.
v. Ownership of university or college: public versus non-public. Hypothesis: Those who graduated from public institutions had a greater intention to work abroad because of the higher quality of their training.
vi. Working organisation: central and provincial hospitals versus others. Hypothesis: Those working in central and provincial hospitals were less likely to intend to work abroad because of their better status and income.
vii. Motivation of finding jobs abroad: yes versus no. Hypothesis: Those who studied nursing with the intention to work abroad had a greater intention to work abroad than the others.
viii. Motivation of high salary and benefits: yes versus no. Hypothesis: Those who studied nursing because they wanted a high salary and good benefits had a greater intention to work abroad because salary and benefits abroad were often better than in Viet Nam.

Table 4.11: Intent to Work Abroad by Socio-demographic and Occupational Characteristics of Nurses

	n	Yes %	No %
Age			
23–35	124	11.3	88.7
Above 35	50	6.0	94.0
Gender			
Men	30	13.3	86.7
Women	170	8.8	91.2
Marital status			
Single	77	15.6	84.4
Married	123	5.7	94.3
Graduation year			
2017 and earlier	142	11.3	88.7
2018 and later	58	5.2	94.8
Ownership of university/college			
Public	107	10.3	89.7
Non-public	93	8.6	91.4
Working organisation			
Central and provincial hospitals	141	8.5	91.5
Others	51	13.7	86.3
Motivation of finding job abroad			
Yes	35	28.6	71.4

No	165	5.5	94.5
Motivation of high salary and benefits			
Yes	77	11.7	88.3
No	123	8.1	91.9

Source: Authors.

The binary logistics models below show some socio-demographic and occupational characteristics of nurses that may explain their intention to work abroad. The full regression model confirms that most of the independent variables are statistically significant in the regression models of each independent variable.

The intention of single nurses to work abroad was much greater than that of married nurses. After controlling for other independent variables in the model, the ratio of odds between the single and the married groups was 6.3, a statistically significant difference ($p<0.01$). The year of graduation had no statistically significant gross effect, but when included in the full regression model, the magnitude of the effect increased and was statistically significant. The odds ratio of intention to non-intention between the group graduating from 2017 and earlier and the group graduating after 2017 was 5,933 ($p<.05$). Another independent variable that had a strong influence on the intention to work abroad was the reason for choosing to study nursing. Nurses with the motivation to work abroad when they chose nursing for their profession are now more numerous than those in the control group. The ratio of odds between the two groups was 6,539 and statistically significant ($p<0.01$).

Men were more likely to intend to work abroad than women, but their intention was only statistically significant at $p<0.1$. Although jobs of men and women are highly dependent on international labour markets, and women are dominant in nursing care, it is possible that international migration is riskier and more disadvantageous to women than to men.

The remaining variables did not have a statistically significant effect on nurses' intention to work abroad. Although the younger age group might have had a greater intention to work abroad than the older age group, the difference was not statistically significant. The first group's opportunity to work abroad was feasible because the current programmes to recruit nurses to work abroad are limited to those 35 or younger. Choosing a nursing career for high income and good benefits was not a significant motivation for intending to work abroad because it was not the primary reason of many surveyed nurses for studying nursing.

The variables in the model can explain about 28.1% of the variation of the dependent variable. However, since the number of respondents intending to work abroad was small, some subgroups had a small number of cases (<5), so they may not be valid for reference.

Table 4.12: Binary Logistic Regression of Intention to Work Abroad by Socio-demographic and Occupational Characteristics and Motivation of Nurses: Viet Nam, 2020

EX(B): ODDS RATIO OF INTENTION/NON–INTENTION

Independent variables	Gross effects[a]		Net effects[b]	
Age				
23–35	1.99		1.336	
Above 35	-		-	
Chi-square	3.09	+		
Gender				
Men	1.59		3.703	+
Women	-		-	
Chi-square	0.603			
Marital status				
Single	0.327	*	6.332	**
Married	-		-	
Chi-square	5.391	*		
Graduation year				
2017 and earlier	2.3		5.933	*
2018 and later	-		-	
Chi-square	1.8			
Ownership of university/college				
Public	1.22		1.398	
Non-Public	-		-	
Chi-Square	0.2			
Working organisation				
Central and provincial hospital	0.59		0.546	
Others	-		-	
Chi-square	1.142			
Motivation of finding job abroad				
Yes	6.933	***	6.539	**
No	-		-	
Chi-square	17.9	***		
Motivation of high salary and benefits				
Yes	1.496		1.587	
No	-		-	
Chi-square	0.7			
Nagelkerke R Square			**0.281**	

Note: +, *, **, *** means statistically significant at 0.1, 0.05, 0.01, 0,001 (2-tailed).
a Gross effects are based on bivariate regressions of the dependent variable on each independent variable.
b Net effects are based on saturated regressions with all independent variables.
Source: Authors.

5.2. Perception of Nurses Intending to Work Abroad

The research aimed to uncover the 'pull' and 'push' factors underlying nurses' reasons for wanting to work abroad as well as working conditions they experienced in Viet Nam. The fact that the number of nurses intending to work abroad accounted for only 9.5% of the total number of interviewees showed that not many nurses were aware of the possibility of working abroad. Those who meet the criteria to work abroad as nurses usually had certain professional and foreign language abilities and were under 35. Therefore, they may have had a better job than others in Viet Nam. This may lead to an assumption that 'pull' factors are important in the intention to work abroad. The mean values for the questions in Table 4.13 show the preferences of the 'pull' factors selected by the respondents. Amongst the factors, 'high salary' had the highest relevance (mean = 3.16 on a scale of 4), followed by 'good relationship between that country and Viet Nam' (2.95) and 'level of skill and technology was higher' (mean = 2.89). Factors related to 'culture and people', 'being able to get a nursing degree abroad', 'becoming a citizen', or 'being able to bring family' had high degrees of relevance to the intent to work abroad. However, except for 'my relatives living there' factor (1.84), the remaining factors were relevant and the differences between them were not significant (2.42–3.16).

Table 4.13: Most Relevant Reasons for Wanting to Work Abroad

Reason	Levels: 1 (very irrelevant) to 4 (very relevant) (%)				n	Mean
	1	2	3	4		
My relatives living there	52.6	26.3	5.3	15.8	19	1.84
Level of skill and technology is higher	5.3	5.3	84.2	5.3	19	2.89
Kind people and fascinating culture	5.3	36.8	52.6	5.3	19	2.58
High salary	0.0	10.5	63.2	26.3	19	3.16
Geographically close to Viet Nam	10.5	31.6	52.6	5.3	19	2.53
Able to become a citizen of that country	5.3	26.3	63.2	5.3	19	2.68
Able to bring family	0.0	31.6	52.6	15.8	19	2.84
Good relationship between that country and Viet Nam	0.0	15.8	73.7	10.5	19	2.95
Able to speak the language of that country	5.3	52.6	36.8	5.3	19	2.42
Able to get a foreign nursing certificate	5.3	15.8	68.4	10.5	19	2.84
Low recruitment fees and easy job application	15.8	26.3	52.6	5.3	19	2.47

Source: Authors.

'Low salary and few benefits' and 'connection/corruption in getting employed and in promotion' were the two biggest difficulties (mean = 2.95), followed by 'danger of the nursing profession' and 'high patient/nurse ratio' (mean = 2.89) and 'bad working conditions' (mean = 2.68). The most significant difficulties reflected the reality of nurses' working environment.

Table 4.14: Levels of Experience that Best Describe Difficulties as a Nurse in Viet Nam

Aspects of difficulty	Levels: 1 (not difficult at all) to 4 (very difficult) (%)				n	Mean
	1	2	3	4		
Communication with domestic patients	47.4	31.6	15.8	5.3	19	1.79
Danger of the nursing profession	0.0	26.3	57.9	15.8	19	2.89
Limited advancement opportunities	5.3	47.4	47.4	0.0	19	2.42
High patient/nurse ratio	5.3	26.3	42.1	26.3	19	2.89
Low salary and little benefits	0.0	31.6	42.1	26.3	19	2.95
Connection/corruption in getting employed and in promotion	5.3	21.1	47.4	26.3	19	2.95
Poor medical facilities	10.5	52.6	31.6	5.3	19	2.32
Bad working conditions	5.3	42.1	31.6	21.1	19	2.68
Difficult relationship with superiors and colleagues	21.1	47.4	26.3	5.3	19	2.16
Insufficient nursing skills and knowledge	26.3	31.6	36.8	5.3	19	2.21
Gender discrimination	36.8	57.9	5.3	0.0	19	1.68

Source: Authors.

The limited number of nurses intending to work abroad wanted to work mostly in developed countries, with Germany and Japan as the most favoured (Table 4.15). The choice was consistent with the fact that the two countries have cooperated with Viet Nam for many years in recruiting nurses and have opened prospects for employment.

Table 4.15: Countries Selected by Respondents to Work as Nurses Abroad

Respondent	1st choice	2nd choice	3rd choice
No.1	Germany		
No.2	Germany		
No.3	Germany	Denmark	
No.4	Japan		
No.5	Japan	Republic of Korea	
No.6	Japan	Cambodia	Singapore
No.7	Australia		
No.8	Australia	Singapore	
No.9	England		

Source: Authors.

Despite the great demand for nurses in developed countries, those who intend to work abroad were aware of the difficulties they may face. The biggest was the 'limited capacity for foreign language' (mean = 2.96) (Table 4.16). The limitation can be said to be one of the biggest, even at the graduate level, and not just for nurses. Of the 200 surveyed nurses, 69.5% said they could use a foreign language, most choosing English, with 88.5% at a basic level, 7.9% relatively proficient, and 3.6% proficient.

Another big difficulty was the 'costs of applying for a job and migration' (mean = 2.95). The low average income in Viet Nam means that the cost of preparing before and during migration is high and beyond many people's ability. Most surveyed nurses had to pay for their education from their salary and family support. The biggest advantage of the two programmes is they solve the two biggest limitations of nursing candidates: foreign language ability and travel costs.

'Lack of confidence when working abroad' was a difficulty that the surveyed nurses mentioned (mean = 2.46) because of limitations in soft skills and cultural adaptation. The respondents felt they had less difficulty with 'limitation of professional knowledge' (mean = 2.22) and were more confident about 'limitation of practical skills' (2.02) or 'lack of working experience' (2.08). Perhaps the intense work in Viet Nam's health facilities had given them confidence in their practical experience.

Table 4.16: Degrees of Difficulty of Nurses Finding Jobs Abroad

	Levels: 1 (not difficult at all) to 4 (very difficult) (%)				n	Mean
Difficult areas	1	2	3	4		
Limitation in foreign language	3.5	18.2	57.1	21.2	170	2.96
Limitation in professional knowledge	18.3	49.7	23.7	8.3	169	2.22
Limitation in practical skills	28.2	45.3	22.9	3.5	170	2.02
Lack of working experience	23.7	49.1	22.5	4.7	169	2.08
Lack of brokerage companies	18.3	46.7	28.4	6.5	169	2.23
Costs of applying for a job and migration	3.0	27.8	40.8	28.4	169	2.95
Health is not guaranteed	28.6	44.0	23.8	3.6	168	2.02
Lack of confidence when working abroad	13.1	41.1	32.7	13.1	168	2.46

Source: Authors.

The COVID-19 pandemic has greatly affected international migration, including of nurses. The survey examined their perceptions of the difficulties they may face when searching for jobs abroad. They were most concerned about 'increased risk of infection from COVID-19' (the pandemic was still a big problem in Viet Nam at the time of survey) (Table 4.17). They were similarly aware of difficulties such as those related to migration restrictions, connection to other people in the destination, possibility of stigma, and employment and income.

Table 4.17: Difficulties in Finding Jobs Abroad Because of COVID-19

Difficult aspects	Levels: 1 (not difficult at all) to 4 (very difficult) (%)				n	Mean
	1	2	3	4		
Entry restrictions	7.5	12.2	41.5	38.8	147	3.12
Limited recruitment of nurses from abroad	6.8	23.8	40.1	29.3	147	2.92
Increased costs for migration	7.5	24.5	48.3	19.7	147	2.80
Reduced salary and benefits	6.2	21.2	46.6	26.0	146	2.92
Increased risk of COVID-19 infection	3.4	10.9	42.2	43.5	147	3.26
Increased risk of being stigmatised	8.2	17.0	47.6	27.2	147	2.94
Difficulty in social communication and life	3.4	25.2	51.0	20.4	147	2.88

Source: Authors.

6. Expected Impacts of International Migration of Nurses on the Health Sector in Viet Nam, and Policy Recommendations

6.1. Expected Impacts of International Migration of Nurses on the Health Sector in Viet Nam

Viet Nam has 11 nurses per 10,000 inhabitants. To achieve the goal of 33 nurses per 10,000 inhabitants by 2030 as per Resolution No. 20/NQ-TU, Viet Nam needs to add at least twice the current number of nurses: It needs to add more than 200,000 nurses. With results of training over the past 10 years and current training capacity, providing so many nurses is a big challenge for training institutions. Many nurses now need to acquire a college or university degree in nursing to meet the standards by 1 January 2025, as per Circular No. 26. /2015/TTLT-BYT-BNV. But training institutions still have limitations such as poor training quality because of the shortage of advanced lecturers who hold doctorates in nursing science, limited foreign-language ability of nursing students, limited nursing knowledge, and limited soft skills.

Although no official statistics on the number of nurses sent to work abroad are available, nurses trained and sent to work in Japan and in Germany through the two programmes signed between government agencies numbered more or less 2,000 or about 200 from each programme per year. Of the many obstacles, the biggest was probably candidates' foreign-language and professional capacity. Because employers were highly selective, the number of people who met their requirements was small. The selected nurses must undergo additional training. The number of nurses sent to work abroad now and the increasing number in the future are smaller than the number of nursing graduates. Most nurses do not even meet the requirements to work abroad. Therefore, the trend of nurses working abroad, although reducing the supply of nurses, has not increased and will not increase demand for nurses in Viet Nam. The trend has had a positive impact on training institutions, encouraging them to improve their training capacity and quality so that foreign employers can employ the nurses they trained. International migration of nurses creates healthy competition in the health sector.

6.2. Policy Recommendations

Viet Nam has issued many policies on human resource development and career development of the nurse workforce that serve the national goals of healthcare and the regional and international integration of Viet Nam. However, many of the goals have not been achieved and a big gap exists between reality and expectation. Thus, our policy recommendations focus primarily on human resource development to meet national targets for quantity and quality of the nurse workforce. Low salaries are a reality for nurses, as they are for those in most public sectors, including other health workers. Therefore, salary reform requires a more holistic policy not only for nurses. The work stress of nurses varies greatly across health facilities, as commune health stations and district hospitals do not have many patients. To a certain extent, only a small number of nurses intend to work abroad as driven by 'pull' factors and by their ability and expertise rather than by 'push' factors. Based on the above standpoints, the research proposes the following:

i. Improve the capacity of training institutions, where developing highly qualified faculty staff in nursing science is key to ensuring quality of training.
ii. Ensure comprehensiveness in training practice, including (a) practical competence, (b) care management and professional development, and (c) law and professional ethics according to the professional competency standards for nursing issued by MOH (2012).
iii. Evaluate the training quality of training institutions according to professional competency standards for nursing.
iv. Develop assessment criteria on knowledge and competency requirements for working nurses according to professional competency standards for nursing.
v. Build policies that bind health facilities to recruit enough nurses based on set targets to reduce the pressure on current nurses.

7. Discussion

Our research attempts to provide a preliminary analysis of the national situation and issues in training and professional development of nurses and of nursing practice in Greater HCMC. The survey encountered difficulties in meeting sample selection criteria that reflected practical nursing problems.

The nurse workforce has yet to meet current quantity requirements and policy objectives. The quality of the nursing profession, especially in foreign-language proficiency and some specific nursing areas, is still limited, reflecting the gap between standards in the country and the high requirements in developed countries.

The tension between domestic and international nursing demand may not be a serious problem in the medium term, assuming that the markets have different selection criteria. However, in the long term, once demand in high-end markets increases, domestically and internationally, it will lead to a shortage of qualified human resources and pose great challenges to training institutions that provide limited training quality.

The above analysis shows that Vietnamese nurses work hard, have practical experience, and can work intensely. But the number of nurses is low compared with the needs of nursing markets. The nursing industry will contribute to the development of Viet Nam and other countries as the population ages and globalisation continues.

In addition to the difficulties mentioned, the limitation of this research is that information from nurses working abroad and who have worked abroad is not available. The number of nurses intending to work abroad is small in the survey sample, leading to certain shortcomings, reducing the validity of the results.

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Chapter 5

Cambodian Caregivers: Human Resource Development and the Option to Work Abroad

Naomi Hatsukano

Cambodia is one of the youngest countries in the ASEAN region but, like other Asian countries, will eventually age. Healthcare workers will be increasingly important. Cambodia has no official system for training professional caregivers for the elderly; family members are the main caregivers. Training caregivers is not in response to demand in the country but in the international market, especially Japan. In other countries, nurses or nursing students are often candidates to work in Japan as caregivers. In Cambodia, however, nursing is considered a domestic profession and the option to work abroad is not popular amongst nurses. Japanese institutes in Phnom Penh are conducting trial-and-error efforts to train caregivers to work abroad. Caregivers with work experience in Japan may support Cambodia's caregiving system in the future.

1. Introduction

Ageing Asian countries have a large and growing demand for healthcare workers. Training will be of increasing importance not only for nurses but also for various health workers, including caregivers for the elderly.

This chapter discusses, first, the situation of Cambodian caregivers, then gives an overview of Cambodia's ageing society to predict demand for caregivers. Second, the chapter discusses the option to work abroad; only candidates qualified to work in Japan are given pre-departure training. Third, the chapter discusses caregiver training in Cambodia and its challenges. This chapter is based on a literature review and interviews, in December 2019 and January 2020, with people working in Japanese organisations that provide pre-departure training to Cambodian

candidates. As Japan started to accept Cambodian caregivers only in late 2018, the number of Cambodian caregivers working in Japan is still small. But with more sending organisations starting to operate in 2018 and 2019, an overview of the situation in its early stage is possible despite limited information available.

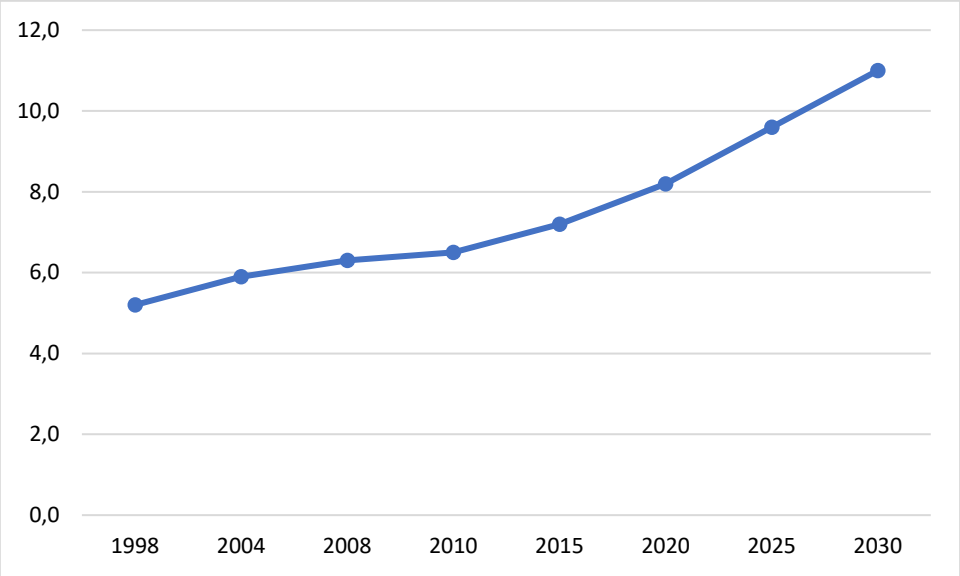
2. Caregivers in Cambodia

2.1. Ageing Society and Caregiving in Cambodia

Although Cambodia is one of the youngest countries in the Association of Southeast Asian Nations (ASEAN) region, it is starting to prepare for the unavoidable ageing of its society. In 2003, the government issued a policy to ensure that the elderly are provided access to opportunities that contribute to national development and to a share in its benefits, and that the elderly live with the same dignity as the young. In August 2017, the National Ageing Policy 2017–2030: To Further Improve Well-Being of Older Persons of Cambodian People was issued (Royal Government of Cambodia (RGC, 2017) to analyse the wider impact of the ageing population and the implications for younger family members in terms of support and care for older persons.

Demographic changes were observed from census data (RGC, 2017). The population under age 15 years old shrank, from 43% in 1998 to 29% in 2003. The population aged 60 years and above grew, from 5% in 1998 to 8% in 2003, and is estimated to be 11% in 2030. The main reason is that average life expectancy has increased because of improvements in food, public health, and other areas. Life expectancy was 54 years for males and 58 years for females in 1998, but increased to 67 years for males and 71 years for females in 2013. Increasing access to quality reproductive services has caused a significant and consistent decline in the fertility rate, which was 5.7 in 1990, 4.1 in 2000, and 2.2 in 2000, and is projected to be 2.1 in 2030. Population projections from 2013 put the growth rate of the over-60 population as much higher than that of other generations, and the proportion of older persons in the total population is increasing (Figure 5.1).

Figure 5.1. Proportion of Older Persons in Total Population in Cambodia (1998–2030)



Source: National Ageing Policy 2017–2030.

The 2017 policy raised these issues: (i) financial security; (ii) health and well-being; (iii) living arrangements; (iv) an enabling environment for older persons' active participation in family, community, social, economic and political activities with freedom and dignity; (v) older people's associations and active ageing; (vi) intergenerational relations; (vii) elder abuse, neglect, and violence; (viii) emergency situations; and (ix) preparing the younger population for ageing. The policy stated that although family members are the main source of caregivers, outsiders would take a more important role in the near future.

2.2. Who Takes Care of the Elderly in Cambodia?

Article 47 of the Constitution states: 'Parents have the obligation to care for and educate their children and children have the duties to care for their older parents according to Cambodian tradition'. Cambodia had no public nursing homes as of the end of 2019. Although some private hospitals in Phnom Penh are starting to accept elderly persons who need special care, this high-quality service comes at a higher price that often only wealthy families can afford. Young family members take on the most important role in caring for their parents. The potential support ratio (population aged 15–64 to population aged 65 and above) declined from 1993 to 2015 from 15.5

to 13.4 and is projected to decline further to 9.3 in 2030 (Table 5.1). The decline is starker in rural areas because of the outmigration of young people to urban areas. Hiring professional caregivers or others to take care of elderly parents will become more realistic.

As of 2020, Cambodia had no association or council for professional caregivers. Most of those who care for the elderly are family members or community health volunteers and not professional caregivers with officially recognised training and licences.

Table 5.1. Rural and Urban Potential Support Ratio in Cambodia (1998–2030)

	Cambodia	Urban	Rural
1998	15.5	20.5	14.5
2004	14.7	18.6	14.1
2008	14.5	20	13.5
2010	13.3	20.3	15.9
2015	13.4	16.2	12.6
2020	11.7	13	10.7
2025	9.8	11.5	9.2
2030	9.3	11.1	8.6

Source: National Ageing Policy 2017–2030.

Training of caregivers in Cambodia started from international migration-oriented institutions responding to international demand for caregivers. In 2018, the first elderly-care centre to train candidates who would work in Japan as caregivers was opened by a Japanese company (David, 2018; Kuntheare, 2018). The government, in cooperation with a Japanese company, is planning to open an elderly-care facility for Cambodians. Caregivers with experience in Japan will be able to support their own elderly when they return.[1] However, the programme has just started and it was not possible to evaluate it as of the beginning of 2020. Trained and experienced caregivers might choose different career paths after returning if no facilities can utilise their experience.

[1] Author's interview with the manager of the school, January 2020.

3. Option to Work Abroad for Healthcare Workers in Cambodia

3.1 Overview of Migrant Workers from Cambodia

Working abroad is a relatively new option for Cambodians. During the civil war and the following years until the early 1990s, Cambodians used to migrate to other countries as refugees. In the 1990s, more people started finding jobs in Thailand, even if the working environment was sometimes dangerous or hard. In the 2010s, more than 1 million Cambodians were working abroad as unskilled labourers. Migrant domestic workers take on significant roles in elderly care in some countries. This section will introduce the general situation of migrant workers from Cambodia.

The most popular destination for Cambodian migrant workers is Thailand because it borders Cambodia and they can travel at a lower cost. They often work in agriculture, manufacturing, and construction. Although some Cambodian domestic workers may be involved caregiving in Thailand, they are outnumbered by women from Lao People's Democratic Republic and Myanmar (Ampika, et al., 2019).

Malaysia and Singapore are two other destination options in ASEAN but they are not as popular as Thailand. Cambodian domestic and factory workers used to work in Malaysia in the early 2000s. However, because of human trafficking and human rights problems, domestic workers have been prohibited from going there since 2011.[2] Cambodians generally do not like to work as domestic workers abroad, and some believe that caregiving and domestic work are similar. Migration to Singapore focuses only on domestic work, although Singapore has limited the number of Cambodian workers to 400 (Tan, 2014).[3]

The Republic of Korea is a more popular destination for young Cambodian workers because its employment permission system allows them to work as general workers, not as trainees, and to receive at least the same minimum wage as Korean workers. Based on the agreement between the governments of the Republic of Korea and Cambodia, workers are being sent to work in

[2] Cambodia and Malaysia signed a memorandum of understanding to restart sending domestic workers to Malaysia. However, as of January 2020, Cambodia had not yet done so.

[3] Author's interview with a staff member of the Association for Cambodia Recruitment Agencies in January 2020, confirming that sending domestic workers to Singapore had not expanded since the first pilot project in 2013–2014.

agriculture, fishery, construction, and manufacturing.[4] The service sector, including domestic work and care work, was not open to Cambodian workers as of January 2020 (Kim, 2020).

Japan has been a destination for workers from other Asian countries since 2007. Until the early 2010s, Japan accepted only a few hundred people under the technical intern trainee system. Since the late 2010s, however, Japan has started to accept more Cambodians, including caregivers.

3.2 Nurse Migration from Cambodia

Skilled workers in Cambodia do not usually migrate. And unlike Filipino or Indian nurses, Cambodian care workers such as nurses do not prefer to work abroad. Most nurses prefer to work only in Cambodia because much of their education and professional examination is conducted in the Cambodian language. Even though some courses are taught in English, proficiency in a foreign language is not necessary for them to finish their education. Some people may study English because it can help them earn better salaries. Or allow them to work in international hospitals or with foreign doctors or nurses in Cambodia[5] to cover the domestic hospitals' lower capacity, support the medical sector's development, or explore business opportunities in medical tourism.

It is rare to find Cambodian nurses working abroad. Some work in hospitals in Thailand that accept Cambodian patients[6] since many Cambodians seek medical treatment there. However, nurses have not used the Mutual Recognition Agreement (MRA) scheme to migrate. A few who studied nursing in Thailand on scholarship have registered as nurses and work in hospitals under the same conditions as Thai nurses. Otherwise, they usually work as assistant nurses, translators, or support staff for Thai nurses or doctors. Registered nurses in Thailand need to pass the exam in the Thai language (Aungsruch and Hatsukano, 2018). Some Cambodian nurses are in Western countries but usually for

[4] As of 2019, Cambodia had sent 54,000 workers to the Republic of Korea (Kimmarita, 2019).

[5] Foreign doctors and nurses can work only with their original country's license if they submit the necessary documents to the Medical Council of Cambodia or Cambodian Council of Nurses.

[6] Not only Thailand but also Viet Nam, Singapore, and other Asian countries accept Cambodian patients in medical tourism. Therefore, Cambodian nurses could possibly be working in those countries, not as nurses but as general staff members.

training or clinical experience for a limited period, or are residents of those countries with Cambodian citizenship but educated there.

4. Migration of Caregivers to Japan: Technical Intern Trainees and Specified Skilled Workers

4.1 Background of Cambodian Workers and Trainees in Japan

Because of the labour shortage in Japan, it has gradually opened its doors to foreign workers and trainees, including Cambodians. The Ministry of Health, Labour and Welfare of Japan and the Ministry of Labour and Vocational Training of Cambodia signed the first memorandum of understanding (MoU) in 2003, and Japan started to accept technical intern trainees (*ginou jisshusei*) from Cambodia in 2007. In 2017, an MoU on technical intern trainees was signed, and in 2019, another MoU on specified skilled workers (*tokutei-ginou*).

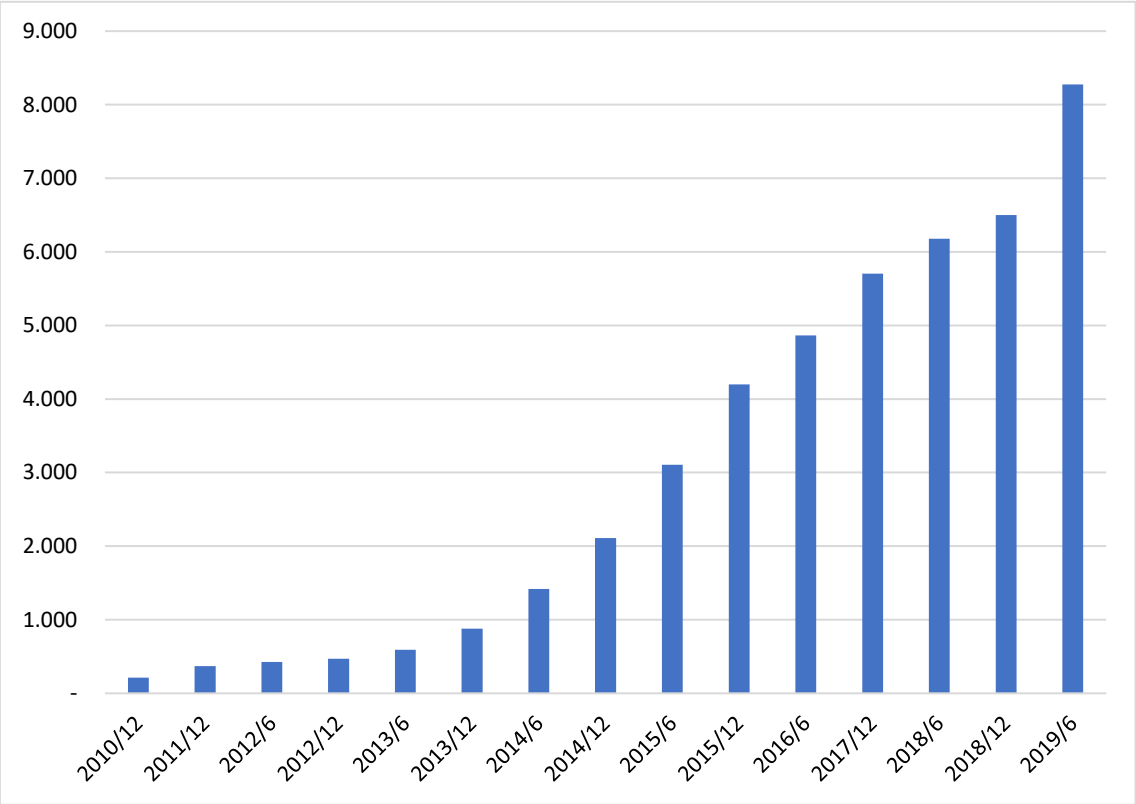
In the first 5 years after 2007, only a few hundred trainees went to Japan. The number increased gradually in the early 2010s. In 2014, the number jumped to more than 1,000, and to 10,000 in 2019 (Figure 5.2).

Most Cambodian trainees were found in agriculture (26.5% in 2018) or construction (23.0%). Garment factories (19.4%) and food-processing factories (12.5%) were popular amongst Cambodian trainees (Organization for Technical Intern Training, 2018). As for the specified skilled workers, 94 Cambodians had passed the exam to obtain the status as of the end of 2019. Amongst them, 74 were working in agriculture (Immigration Service Agency of Japan, 2019).

All sending organisations that conduct pre-departure training and other procedures for Cambodian trainees and workers must be registered with the Ministry of Labour and Vocational Training of Cambodia. In 2012, 10 organisations were registered with the ministry to send trainees to Japan although, by October 2012, only three organisations were able to do so (Hatsukano, 2014). As of June 2020, 94 organisations had registered with the ministry to send trainees and workers to Japan as newer organisations registered after the 2017 MoU.[7]

[7] From the Organization for Technical Intern Training as of 26 June 2020. The author's interviews with relevant organisations in January 2020 found that 114 were registered as of the end of 2019. However, the number declined after the interviews.

Figure 5.2. Number of Technical Intern Trainees from Cambodia (2010–2019)



Source: Ministry of Justice, Japan (accessed 22 February 2020).

3.2 Caregiver Candidates to Japan

This section discusses sending Cambodian caregivers to Japan, based on official statistics and interviews with Japanese and Cambodian managers working with Japanese organisations and six organisations or schools in Phnom Penh. The six organisations or schools include two schools focusing on training caregivers, two organisations that have started sending caregivers to Japan, one sending organisation interested in starting to send caregivers, and one sending organisation not interested in sending caregivers.

Japan has in recent years started to accept Cambodian technical intern trainees and specified skilled workers in the caregiving sector. Although technical intern trainees and specified skilled workers are not nationally certified caregivers (*kaigo fukushi-shi*), they work at nursing homes to support certified caregivers. Technical intern trainees will work for 3 to 5 years and specified skilled workers will work for another 5 years maximum. Once they pass the national exam for

certified caregivers, they can work in Japan for as long as they wish.

As of the end of 2018, 99 Cambodian technical intern trainees were in Japan (Organization for Technical Intern Training, 2018). According to the Japanese managers, before Cambodian technical intern trainees are sent to nursing homes as caregivers, they must study for 10–12 months, usually from 8 AM to 5 PM, Monday to Saturday. They do physical exercises and clean classrooms as is done in schools in Japan, and study the language and skills necessary to work in nursing homes. The language level and skills required for care work are much higher than those for agriculture and other sectors because care workers must communicate with the elderly and other professional healthcare workers. N3 level (or equivalent) of Japanese language proficiency is preferred and N4 (or equivalent) is required.[8] Any background in Japanese language or nursing or medical education is advantageous for caregivers since such people are few in Cambodia.

In early 2018, a Japanese sending organisation collaborated with the faculties of nursing of local private universities to find better candidates for nursing homes in Japan.[9] Because of their basic medical knowledge, the nursing students are easier to train as caregiver candidates than those without basic Japanese language or medical knowledge.

In inviting caregiver candidates from Indonesia, the Philippines, and Viet Nam to Japan, the economic partnership agreement (EPA) scheme requires 3–4 years education in nursing, a government license for caregivers in their countries, amongst others. N3-level proficiency in Japanese language is required from candidates from Viet Nam, and N4 level from Indonesia and the Philippines. Unlike EPA caregivers, technical intern trainees do not have to submit or possess such requirements, except basic caregiving and Japanese language skills or knowledge sufficient to communicate with professional staff and the elderly in nursing homes. Demand from Japan for such candidates is greater than the number of candidates from Cambodia. Nurses can be good candidates but not many Cambodian nurses wish to work as care workers or caregivers in foreign countries. The nursing education system in Cambodia is designed to be consistent with

[8] N1 is a level of the Japanese-language exam. N1 and N2 measure the level of understanding of the Japanese language used in a broad range of scenes in everyday life. N4 and N5 measure the level of understanding of basic Japanese mainly learned in class. N3 is the bridging level between N1 and N2 and between N4 and N5 (Japan Foundation and Japan Educational Exchanges and Services, unknown) (accessed 10 March 2023).

[9] Since the organization was not active as of the beginning of 2020, it was not included in the six the author visited and the author failed to confirm the state of their collaboration with the faculty of nursing in Cambodia.

the other ASEAN countries in achieving MRA (Law et al., 2019; Koy, 2016; Ly, 2018). However, Cambodian nurses are not much interested in working abroad. Besides, the country has no official system to train professional caregivers. Therefore, most candidates who wish to work as caregivers in Japan must start their pre-departure training without basic knowledge of nursing or other relevant skills.

In 2018, Japanese private companies established schools or institutes to provide technical training for Cambodians who wished to work or train in caregiving in nursing homes in Japan (section 1.2). The schools have special facilities copied from nursing homes in Japan, including slopes, handrails, toilets, showers, and other facilities. They have invited special lecturers from Japan to teach skills. Some schools have developed special Japanese-language textbooks to teach technical words to care workers.

The schools, institutes, and sending organisations recruit candidates from all over the country, usually through friends of former candidates or family networks, and house them in dormitories. Recently, more organisations have put up Facebook pages to disseminate recruitment information.

An optimistic Japanese school manager shared this view:

Most candidates are from various provinces, with high school level or even lower educational backgrounds, although some are graduates of universities (not of nursing). As not many people have opportunities to go to school, an individual's ability and personality are more important than just their educational background. If the schools provide better training, they can improve the candidates' abilities.

However, not all Japanese sending organisations are as positive. Said a manager of a smaller training organisation:

If candidates have Japanese-language proficiency to some extent before joining the pre-departure training, it can help them adjust and learn more effectively. It is easier for large sending countries, such as Viet Nam or Myanmar, to train candidates. Providing pre-departure training for caregivers in Cambodia is not very cost-effective.

In the specified skilled workers field, exams had been held four times in Cambodia by the end of December 2019 (Table 5.2). The ratio of successful applicants was significantly lower than that

of other countries. Some school managers have stated that information about the exams is not disseminated thoroughly enough to the concerned people or organisations. Cambodia started to send trainees in 2007 but has accelerated the process only recently. Therefore, their experience is still limited. Other countries, such as Indonesia and the Philippines, are sending more nursing and caregiving trainees and candidates through EPAs. Cambodia will need more time to learn how to train candidates to pass the exams.

Table 5.2. Number of Passers of Examinations for Japanese-language Proficiency of Specified Skilled Workers in Caregiving

Cambodia				
		Applicants	Successful	Rate
2019/9	Skill	91	6	7%
	Japanese	94	24	26%
2019/10	Skill	114	4	4%
	Japanese	110	6	6%
2019/11	Skill	15	3	20%
	Japanese	12	8	67%
2019/12	Skill	35	3	9%
	Japanese	27	2	7%

The Philippines				
		Applicants	Successful	Rate
2019/9	Skill	241	104	43%
	Japanese	235	102	43%
2019/10	Skill	53	42	79%
	Japanese	47	38	81%
2019/11	Skill	570	374	66%
	Japanese	557	336	60%
2019/12	Skill	253	177	70%
	Japanese	243	159	65%

Nepal				
		Applicants	Successful	Rate
2019/9	Skill	-	-	-
	Japanese	-	-	-
2019/10	Skill	15	0	0%
	Japanese	12	1	8%
2019/11	Skill	52	14	27%
	Japanese	54	13	24%
2019/12	Skill	33	7	21%
	Japanese	37	7	19%

Indonesia				
		Applicants	Successful	Rate
2019/9	Skill	-	-	-
	Japanese	-	-	-
2019/10	Skill	46	17	37%
	Japanese	46	27	59%
2019/11	Skill	74	34	46%
	Japanese	72	38	53%
2019/12	Skill	120	49	41%
	Japanese	107	52	49%

Mongolia				
		Applicants	Successful	Rate
2019/9	Skill	-	-	-
	Japanese	-	-	-
2019/10	Skill	-	-	-
	Japanese	-	-	-
2019/11	Skill	74	49	66%
	Japanese	70	51	73%
2019/12	Skill	58	25	43%
	Japanese	60	19	32%

Source: Ministry of Health, Labour and Wealth, Japan.

Conclusion

Although Cambodia is one of the youngest countries in the ASEAN region, ageing of its society is unavoidable. As of 2020, most of those who cared for the elderly were family members or community health volunteers and not professional caregivers with officially recognised training and licences.

Japan has been accepting more caregivers from Asian countries since 2018, including Cambodia. As professional caregiving is relatively new in Cambodia, the number of trainees and workers in this field is still limited. Although some schools started to train caregivers in Cambodia in 2018, more effective training is necessary to meet demand from the Japan side. Although some schools seem to be successful and some seem to face difficulty, more time is needed before human resource development can be fully evaluated.

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Chapter 6

Indonesian International Nurse Migration: Assessing Migration as Investment for Future Work

Aswatini Raharto

Mita Noveria

1. Introduction

International labour migration is a complex global phenomenon connecting countries of origin and destination as suppliers and users. Origin and destination countries benefit economically from labour movement in different ways. Indonesian migrant workers (IMWs) work abroad to earn more as their country has limited job opportunities (Aswatini, 2006; Raharto, 2013, 2017). Data for 2014–2020 show that 64%–72% of IMWs had at most a junior high school education. As of 2020, IMWs made up 33%–58% of the formal sector;[1] the proportion decreased during the coronavirus disease (COVID-19) pandemic, from 48% in 2019 to 33% in 2020 (Anaf et al., 2022). Even though most IMWs have modest levels of education, their employment and income prospects can be viewed as a return on an investment made before leaving Indonesia. Some countries in Asia are well known as global suppliers of nurses, the Philippines being the most significant (Matsuno, 2009). Indonesia is not widely recognised as a worldwide provider of nurses, although the deployment of Indonesian nurses to work in the United Arab Emirates, the Netherlands, Kuwait, the United Kingdom, and Saudi Arabia, amongst others, began in 1996 (Efendi et al., 2019). Indonesia sent nurses to the Netherlands in 1969–1974, at the Dutch government's request, but stopped in 1974 (Hosen and Raharto, 2013). Recruitment of Indonesian nurses was first dominated by private agencies, then by the government under the Migrant Workers Protection Agency (Badan Perlindungan Pekerja Migran Indonesia, BP2MI), through several placement mechanisms, namely government to government/private (G to G/P), private to private (P to P), independent, and for the benefit of the company (Kurniati et al., 2020). The regulation on placement of Indonesian nurses abroad through a government scheme is based on a bilateral agreement that started in 2008 with Japan and was followed by Timor Leste (Efendi, 2019).

Many developed countries such as the United Kingdom, Japan, and Germany have a shortage of nurses and must recruit nurses from abroad (World Health Organization, 2020), especially because their populations are ageing. The situation allows countries with a surplus to place their nurses in such

[1] The formal sector has an organised system of employment with clear written rules of recruitment and agreement, and has a standardised relationship between the employer and the employee that is maintained through formal contract. The employee is expected to work fixed hours and receive a fixed salary in addition to incentives and perks. He/she has to work in a decent environment and is entitled to benefits such as leave, savings, loans, and others. He/she has an organised association or union where his official grievances are addressed. Besides, he/she is covered under social protection benefits such as life insurance, health insurance, pension, gratuity, and others (FundsforNGOs, 2009).

countries. Nurses migrate from countries in Asia, Africa, and the Caribbean to the Middle East and to countries in the same Asian region (WHO, 2020).

The number of nursing school graduates has exceeded Indonesia's needs. In 2018, the ratio was 2.46 nurses per 1,000 population, above the government's target of 1.8 in 2019 and 2.0 in 2025. The availability of nurses nationwide can be seen from the number of nurses assessed as competent to practice nursing, as evidenced by their *surat tanda registrasi* (STR),[2] which is valid for 5 years. (Kurniati, 2020; Astari and Efendi et al., 2020). By the end of 2020, the cumulative number of nurses who were registered and had received an STR was 985,889. But only less than half reported working in hospitals, public health centres (*puskesmas*), and other health facilities (Efendi and Kurniati, 2020; Kurniati et al, 2020). The rest may be assumed to be working in fields other than health or to be unemployed (Efendi and Kurniati, 2020)

Based on the projected need for nursing staff and the number of nursing school graduates, Indonesia will experience an estimated nursing staff surplus of 695,217 in 2025 (Kurniati et al., 2020). However, the distribution of nurses is uneven, so some provinces have a ratio above the national target and some below (Efendi and Kurniati, 2020; Raharto and Noveria, 2020). The data show that Indonesia has the potential to send nurses to work abroad. However, their placement has not taken advantage of global job opportunities.

Data for 2017–2021 show that placement of Indonesian health workers (including nurses, caregivers, and care workers) abroad was highest in 2019 and decreased in 2020 and 2021 (Table 6.1). The decrease in 2020 and 2021 could have been influenced by the COVID-19 pandemic, which limited internal and international mobility. Caregivers had the highest number of placements, but how many are nursing school graduates is unknown; not all caregivers need to graduate from nursing school. Some are senior high school graduates who trained as caregivers to prepare to work abroad.

Table 6.1. Placement of Indonesian Migrant Workers as Nurses, Caregivers, and Care Workers, 2017–2021

Position	2017	2018	2019	2020	2021
Caregiver[a]	44,033	51,353	55,125	23,452	5,403
Care worker[a]	na	na	309	354	295
Nurse	240	227	232	85	NA
Total	44,273	51,580	55,666	23,891	5,698

NA = data not available.

[a] 'Caregiver' and 'care worker' are used in different countries to refer to nurse or other qualified worker caring for the elderly and/or children.

Sources: BNP2TKI, 2019, 2020; BP2MI, 2021, 2022.

Table 6.2 shows the placement of Indonesian nurses in Japan under the government-to-government scheme, 2017–2020. The data are separated by job title, nurse, and care worker. Care workers, mainly women, dominate placement through Japan's government-to-government scheme. The placement is under the Indonesia–Japan Economic Partnership Agreement (IJEPA) programme, which started in 2008. Placement of nurses is divided into prospective care workers (*kaigofukushishi*) and prospective nurses (*kangoshi*). Prospective care workers must have at least a DIII,[3] and DIV or S1 Nursing.

[2] The STR is issued by the Health Workforce Council to health workers who have a certificate of competence. Health workers with an STR can provide health services (Kurniati, 2020; Astari and Efendi et al., 2020).

[3] DIII or Diploma III is the 3-year nursing course at a nursing academy, after finishing 3 years of senior high school. Diploma IV is equal to S1 or bachelor of nursing from a university faculty of nursing (Shobichatul,Wardoyo, and Pangastoeti, 2018; Raharto and Noveria, 2020).

Prospective nurses must have those as well as an STR and 2 years of nursing experience starting from the date of issue of the STR (Shobichatul, Wardoyo, and Pangastoeti, 2018).

Table 6.2: Placement of Indonesian Migrant Workers to Japan Based on Position, According to the Government-to-Government Scheme, 2017–2020

Year	Nurse		Care Worker		Total
	Male	Female	Male	Female	
2017	7	22	94	201	324
2018	11	20	110	188	329
2019	15	23	99	201	338
2020	8	15	82	190	295

Sources: BNP2TKI, 2019, 2020; BP2MI, 2021.

The 'desire' or 'plan' to work abroad can be a driving factor for investment in human resources. One way to invest is through formal and informal education, such as training in certain skills and expertise needed in the region or country where they will work (Aswatini et al., 2019). Migration itself can be seen as an investment in human capital, considering that it requires resources to cover costs incurred by migrants or prospective migrants. The returns obtained include higher income and access to better opportunities (Sjaastad, 1962). Another return is improved skills and insights from working abroad, which can be considered capital for future work.

2. Labour Migration and Human Capital Investment

Human resource investment analysis refers to understanding two definitions: human resources and human capital. Human resources can be defined as a group of people who make up an organisation's workforce that can be utilised by the organisation to achieve its goals and to improve itself (Hadi, 2015; Heathfield, 2021; Betterteam, 2022).

Human capital is the capacity of human resources. It can be broadly defined as knowledge, skills, health, and other personal characteristics, including motivation, social values, and attitudes, as well as communication skills that can increase productivity (Hertog, 1999; Eide and Showalter, 2010; Bottone, 2018; Longley, 2021; Lulle, Janta, and Emilsson 2021; World Bank, 2022; Amadeo, 2022; Kenton, 2022).

Individuals accumulate human resources or capital throughout their lives. Such capital is enhanced through investment in the form of education, skills training, on-the-job training and experience in the workplace, nutritious food, and healthcare (Becker, 1962, 1975; Schultz, 1961, 1971, 1981; World Bank, 2022). Human resource investment is an activity requiring the sacrifice of resources incurred by individuals to get a return: higher income and employment status.

In the human capital model, migration is an investment (Schultz, 1961; Sjaastad, 1962; Becker, 1962, 1975), one that increases the productivity of human resources through analysis of the cost and return of migration (Sjastaad, 1962). Migration is an investment that requires resources that must be allocated in the form of migration costs, which can increase the productivity of individual migrants. The costs are money and non-money. Money costs are from all expenses incurred during the migration process, whilst non-money costs include loss of income (of previous work in the area of origin). Non-money costs are 'psychic' costs, including, amongst others, adjustment to conditions in the

destination and the burden of leaving family, relatives, and friends. 'Psychic' costs do not involve calculating economic resources but greatly influence migration. Migration will occur when 'psychic' costs can be overcome. The benefits are assessed in economic terms: better employment and income than in the area of origin. The returns obtained from migration include, first, money (a higher income than in the migrant's own country) and access to better opportunities than current activities. The second return is non-money, arising from increased individual work efficiency and productivity (Sjaastad, 1962).

This chapter does not address the money and non-money migration costs or the analysis of money return but focuses on understanding the non-money return gained by nurse migration, assuming that working abroad is an investment. The non-money return of migration is increased efficiency and productivity (Sjaastad, 1962). The non-money return can include improvement of the quality of migrant workers' human capital: increased individual and specific skills such as language proficiency (Adda, Dustmann, and Görlach, 2021), interpersonal skills, self-confidence, and knowledge gained from migrant work (Lulle, Janta, and Emilsson, 2021). It is important to understand whether the non-money return increases human capital that will affect future work.

3. The Study

Indonesia is the second-largest migrant worker–sending country in Southeast Asia after the Philippines, especially of female workers (International Labour Organization, 2015; McAuliffe et al., 2019; IOM, 2019). The main factors influencing Indonesian workers to migrate and work abroad are economic, including lack of good jobs and low wages (push factors) as well as high wages abroad (pull factor) (Raharto, 2002, 2013; World Bank, 2017). However, a study conducted amongst Indonesian nurses who used to work abroad and nurses working in Indonesia who never worked abroad showed that economic factors were not always the main reason to work or to desire to work abroad. An important reason was to gain work experience, improve skills, and acquire better career development opportunities (Raharto and Noveria, 2020)

IMWs go mainly to Malaysia, Taiwan, Hong Kong, and Singapore in Asia, and mainly to Saudi Arabia in the Middle East (BP2MI, 2021, 2022). In 2020 and 2021, during the COVID-19 pandemic, Taiwan and Hong Kong were the main IMW destinations, as they needed care workers to look after their rapidly increasing elderly (Wen-Chi, 2019; Wong and Yeung, 2019).

Nurses and care workers make up a small share of IMWs: 20% in 2019, 21% in 2020, and 9% in 2021 (BNP2TKI, 2019, 2020; BP2MI, 2021, 2022). Indonesia has excess of nursing graduates but this has not led to increase in deployment of nurses to work abroad. From 2015 to 2020, only 6,393 IMW nurses worked abroad (Kurniati, et al., 2020). They held positions as nurses, nursing assistants, or care workers in elderly-care institutions. Some problems that hindered placement abroad included the general lack of competency of available nurse graduates vis-a-vis demand in the destination country and the nurses' lack of interest in a career abroad (Kurniati et al., 2020).

Indonesian nurses with work experience abroad and returning to their country are expected to improve some skills based on their work experience and certifications. This study aims to understand whether the benefits that Indonesian nurses gain from working abroad are capital for future work. The analysis covers issues related to reasons for working abroad; intention to work abroad (amongst nurses who did not have experience working abroad); skills improvement gained from working

abroad; reasons for returning to Indonesia; economic activities after returning to Indonesia; and migration as investment, considering skills improvement from working abroad as capital for future work.

The study applies a qualitative approach. Data were collected through in-depth interviews with informants: 12 nurses who had worked abroad and returned to Indonesia, and 10 who were working in Indonesia and had no work experience abroad. All had at least a DIII nurse education. Data collection began in early 2020, but because of the COVID-19 pandemic, interviews were suspended and resumed only in early 2022. Data analysis is descriptive to understand the purpose and experience of IMW nurses working abroad in relation to investment in human capital that can provide returns in term of skills improvement that will benefit future work. The data collection was funded by the Economic Research Institution for ASEAN and East Asia (ERIA) under the project on Human Resources Development, Employment and International Migration of Nurses and Caregivers in Asia and the Pacific Region, 2020–2022.

4. Findings

4.1. Reasons for Working Abroad

International migration occurs for a variety of reasons, based on push factors in the country of origin and pull factors in the destination country (Lee, 1966; Hofmann et al., 2020; Koczan et al., 2021). The reason for working in a foreign country can be interpreted as a pull factor whilst reasons for leaving the origin country as push factors. Pull and push factors can be economic, social, and political. Pull factors of destination countries can include higher income, better jobs, and opportunities for career development, whilst push factors can include limited jobs, poverty, and natural disasters in the origin countries.

The nurse informants cited three main reasons as pull factors for working abroad: earning higher income, acquiring work experience, and improving career development by increasing nursing science knowledge.

The economic factor (earning a higher income) was the most important reason stated by 7 of the 12 informants (Appendix). The intention was to help improve the family's economic condition**,** as stated by MG6,[4] MG8, and MG5.

MG6, a female nurse who had worked in the United Arab Emirates for 20 years as a nurse and was promoted as deputy section chief (Appendix), explained that her salary in Indonesia was not enough to meet even just her personal needs. She had expected a high salary after graduating from a nursing school.

MG8, a 30-year-old female nurse who had worked in Dubai as a caregiver and in Saudi Arabia as a nurse, said she was working abroad to register as a nurse with a greater salary and incentives and to increase her quality of life.

Working abroad and earning a high salary allows nurses to save money to pay for further education, explained MG5, a 44-year-old male nurse with a DIII in nursing and who had been a nurse in a Kuwait

[4] MG refers to a nurse and caregiver informant who had worked abroad. MG6 means informant number 6 (Appendix).

hospital for 12 years. In 2015, MG5's salary in Kuwait was IDR40 million per month, 10 times higher than his salary would be in Indonesia.

Three of the 12 nurses who had worked abroad said they expected and wanted to gain experience by working abroad. Not all of them worked as nurses, so their experiences were not all related to clinical work as nurses, explained MG1, MG2, and MG4. MG1, a 43-year-old female nurse, had worked in an international non-governmental organisation (NGO) in Zimbabwe preventing HIV transmission from mother to child. Before going to Zimbabwe, she had worked with the same NGO in Indonesia, where she mainly managed the programme whilst working closely with people with HIV at clinics and hospitals.

MG2, a 41-year-old female nurse, went to Japan as a nurse candidate (*kangoshi*) under the IJEPA programme. She passed Japan's national examination on her third try. However, she did not continue working in Japan as she had to go home to get married and take care of her sick and aged father.

MG4, male, 49 years old, worked in Singapore from 2002 to 2006 and returned to Indonesia at age 34. He said he had wanted to gain experience and insights by working abroad so he applied to work in Saudi Arabia. The process was not as easy as he had thought and applying for a working permit was complicated. He was finally deployed to Singapore by a labour-sending agency.

Three (MG7, MG9, MG12) of the 12 nurse informants worked as caregivers. All stated that the main reason for working abroad was the higher salary and incentives, which could help improve their family's economic condition. They cited some non-economic reasons such as 'improved language ability' (referring to the language of the destination country). None cited 'to increase knowledge and skill' as reason for working abroad. Their reasons were likely based on what they had done and gained working abroad. Deskilling of Indonesian nurses who worked as caregivers abroad often begins on the first day of work as a caregiver, when they are shocked to be allowed to perform only duties such as feeding, bathing, and walking patients, and not the clinical duties they used to perform in Indonesia (Kurniati, Chen, Efendi, and Ogawa, 2017). However, their salaries as caregivers were certainly higher than those of nurses in Indonesia.

4.2. Intention to Work Abroad

The 10 nurse informants who had never worked abroad had all worked as nurses in clinics and hospitals after their nursing education (diploma of nursing or bachelor of nursing [Appendix]), indicating that continuity of work as a nurse in Indonesia is sustainable. Although some had changed work places, they were still working as nurses. Five expressed the intention to work abroad, and two cited economic reasons for wanting to work abroad: 'to change fate' and 'earn a higher salary.'

Parents seemed to have had an important influence on nurses' decision to work abroad. NMG1[5], for example, had made all preparations to work abroad only to cancel the plan because her parents did not permit her to leave.

The nurses who had no intention to work abroad said their reasons were family and the convenience of working in Indonesia.

Clearly, nurses who had not worked abroad but were intent on doing so cited economic and non-economic reasons as important pull factors, whilst the family might be a restraining factor that kept

[5] NMG, non-migrant, refers to a nurse and caregiver informant who has not worked abroad. NMG1 means informant non-migrant number 1 (Appendix).

them working at home. The importance of family influence on nurses' decision to work abroad was found in a 2018 survey; about 71.4% of the nurses did not have any intention to work abroad because 'family did not approve of working abroad' (Raharto and Noveria, 2020).

4.3. Improved Skills from Working Abroad

Working abroad can improve the quality of Indonesian nurses, especially in foreign-language proficiency , which is mainly related to language training they must take before leaving and language practice whilst working abroad. They have the opportunity to improve work-related skills and general skills, such as ability to communicate, knowledge of different work systems and cultures, and systematic work. However, some country-specific skills are not transferable, which means some skills lost their value in the destination countries (Emilsson and Mozetic, 2021), e.g., native language skills and work culture.

Local language skill or proficiency was cited as a common improvement by Indonesian nurses and caregivers working abroad, as they have to understand the country's language—and English—to better perform their duties. Language can be learnt in Indonesia in preparation for their work and can be improved as they work abroad through formal training (Mutiawanthi, 2017) or daily communication with local people.

MG7, who had worked as a caregiver in Taiwan, explained that she could not master Mandarin by the time she left Indonesia as she had only 3 months to learn it. She said that in Taiwan, the ability to read and write is not important; what matters most is to converse, which she eventually could.

Indonesian nurses improve their nursing skills through training and practical work in certain areas of specialisation and as assigned by their workplace. MG4, a nurse in the neuro section of a hospital in Singapore, said work there is highly focused on assigned tasks and she trained to confirm diagnoses.

MG5 said he improved his nursing skills in Kuwait as a result of working, for the first time, in a psychiatric hospital. He attended seminars, something he had never done in Indonesia.

Some nurses' jobs might not always be directly related to clinical nursing. MG1's work for the HIV prevention NGO in Zimbabwe was mainly programme management and advocacy in clinics and hospitals. She said that working abroad improved her ability and skills to communicate and negotiate with her superiors.

MG6 had 20 years' experience working in the United Arab Emirates, where she first worked as a general nurse until she was promoted to deputy section chief in a government hospital. The new position mostly involved hospital management rather than clinical duties. She said that her work allowed her to learn much about people of various nationalities.

The nurses said the skills expected of them were not different from what they had learned in Indonesia. MG2, who had worked as a nurse in a rehabilitation centre hospital in Japan talked of improved self-confidence and general knowledge. She said nursing knowledge is basic, and that the differences lie in the surroundings and culture, including systems, work discipline, teamwork, and division of labour.

Of the nurses who had worked abroad as caregivers, all said that the main skill they had improved was mastery of a foreign language, as their work did not need clinical nursing skills (Kurniati, Chen, Efendi, and Ogawa, 2017). They increased their language proficiency by communicating daily with local colleagues and others. MG7, a 35-year-old nurse who worked as a caregiver at a nursing home in

Taiwan, said she learned much through practical work as a nursing assistant, receiving guidance from officers on how to care for sick elderly. However, she said she was never allowed to perform medical and nursing actions or interventions such as inoculating patients.

Indonesian nurses working as nurses abroad enhanced their skills by attending specialised training in their field of work and doing specific tasks. Some nurses did not perform clinical work because they were in a management or administration department, although such position is considered a promotion, with a higher salary. For nurses who worked as caregivers, they were most likely deskilled as they were not allowed to perform medical and clinical interventions. Deskilling often began on the first day of work, when they performed duties such as feeding, bathing, and walking patients, or tasks that were different from those in Indonesia (Kurniati, Chen, Efendi, and Ogawa, 2017; Mutiawanthi, 2017). As the nurses were unfamiliar with the caregiver job description, they could not anticipate what they had to do (Nugraha and Hirano, 2016). The most important skill Indonesian nurses and caregivers gained from working abroad was language proficiency, although such proficiency may not be transferable should they work in another country.

4.4. Reasons for Returning to Indonesia

Migration of nurses across national borders is part of international labour migration, which is mainly driven by economic reasons. Labour migration occurs because of differences in economic opportunities (Todaro, 1980). In the context of international nurse migration, jobs that offer higher salaries are available in some countries. According to the theory of the new economy of labour migration (NELM), workers migrate to obtain economic and non-economic benefits. They stay in a destination country to achieve specific goals. Once they have done so, they return to their country or region of origin and use the outcome to conduct economic activities (Cassarino, 2004).

In line with the NELM theory, migrants, including international workers, migrate temporarily and return to their country of origin at a certain time (Krieger, 2008), and those who leave their country want to return some time (Battistella, 2018). Returning to the country of origin is the closing phase of the migration process (Callea, 1986).

Migrants who return to their area or country of origin are called return migrants. Return migration is the movement of migrants after staying in another country for some time and intending to remain in the country of origin for at least 1 year (United Nations, 1998; Gmelch, 1980[6]). Migration to the home country is voluntary (Dustmann and Weiss, 2007).

American migrant workers returning to southern Italy, for example, were categorised into four groups (Cerase, 1974):

> *those who failed to get the jobs they expected (return of failure);*
>
> *those who had accumulated sufficient savings in the destination country and intended to return to the origin country and buy a plot of land (return of conservatism);*
>
> *those who spent their economically productive years working in the destination country and returned to their country of origin to retire (return of retirement); and*

[6] He used the same definition but did not mention the time reference.

those who intended to stay in the destination country for a certain time to accumulate financial capital by saving part of their income, after which they returned to their home country and used the money for applying innovation strategies in economic activities (return of innovation).

Return migrants may be grouped into three clusters, based on a study of Albanian migrant workers returning from Italy and Greece (Garcia-Pereiro, 2018):

those who faced integration problems, unpleasant social and cultural circumstances, and retired in destination countries;

those who finished their education and training in the destination countries; and

those who lost their job in destination countries; had family and health problems; finished their working contracts; did not have a permit to extend their stay in the destination countries; or missed their origin countries, where they had better job opportunities and could invest and engage in economic activities.

This section discusses why the informants returned to Indonesia after working abroad. Although the underlying reason for migration is economic, the reasons for returning to the origin country are not just economic but also family ties and a feeling of comfort.

4.4.1. Expiration of Employment Contract

Nurses migrate based on employment contracts, usually with a hospital or a clinic. In some countries, the contract period is 2 years, which can be extended upon agreement by both parties. MG4, a male nurse who had worked at a hospital in Singapore, reported that his employment contract was for 2 years, which was extended for another 2 years. He returned to Indonesia after the extended employment contract expired. He spent his income on building a house.

Although those who had completed their employment contracts could extend their stay in the destination country, some did not do so as they had met their financial target, which is in line with the findings of the study on Albanian return migrants (Pareiro, 2018). Several conditions in the country of origin prevented some informants from extending their employment contracts.

4.4.2. Caring for Sick Parents

Some informants left their elderly parents behind. Most Indonesians strongly value caring for the elderly, especially the sick and dependent, and some informants did not extend their contracts for this reason.

Several studies found that family and social connections influence migration. Strong family and social bonds in the place of origin can prevent an individual from migrating (Hugo, 1981), whilst family members, relatives, and friends in the destination area can encourage migration (Cuba, 1991). This study found that strong family ties and the need to care for sick parents led some informants to return to Indonesia. Migrant workers returning to care for the elderly occurs in other countries, too, such as China (Liu et al., 2018).

4.4.3. Furthering of Education

One reason that informants work abroad is to earn more. Wages earned overseas are spent for various purposes, including higher education. MG7, who worked abroad after completing 3 years of nursing education, expressed the desire to further her education to earn 4-year bachelor's degree (S1). She saved a huge part of her salary in Taiwan. After returning to Indonesia, she enrolled at a university in

Semarang, Central Java. An informant who had worked in Kuwait for 2 years (MG5) and another in the United Arab Emirates for 20 years (MG6) returned for the same reason.

Migration has money and non-money returns (Sjaastad, 1962). Non-money returns include accumulation of knowledge and skills that can be used when migrant workers return to their place of origin. Of our informants, some wished to further formal education, not just acquire work knowledge and skills. In some countries, migrant workers can pursue formal education because some NGOs provide access to it (Aswatini et al., 2019). As the study's informants were unable to take formal education whilst working in the destination country because of the high cost, they returned to Indonesia to continue their education, using the income earned abroad.

4.4.4. Married and Raising Children

Economic, family, and social factors play a role in migration. Social factors influence not only the flow of migration from place of origin to destination area but also the reverse flow. This study found that some informants returned to Indonesia for family reasons (other than caring for sick parents), even though they still wanted to extend working abroad.

Two informants' stories show how important family ties are in migration, including labour migration. MG2 had passed the nursing examination in Japan after her third try but returned to Indonesia to get married. Her husband wanted to join her in Japan but never passed the test. MG1 worked in an African country but returned to Indonesia and stayed because she gave birth, and her husband was against her leaving as they had been apart for so long.

4.4.5. Homesickness

Another reason for return migration is the desire to live in the familiar social and natural environment of home (Pareiro, 2018). MG5 said she missed Indonesian food, the beauty of her country, the ability to travel anywhere, and live music. Great differences in environments and ways of life make migrants homesick, despite their higher incomes.

4.5. Activity after Returning Home

This section discusses the economic activities of informants after returning to Indonesia. They can be categorised into three groups based on their jobs and economic activities. The first include those who still worked as nurses in health facilities (five former nurses and two former caregivers overseas). The second group includes those who were not practicing nurses but were performing other economic activities. Two former nurses in Singapore and Kuwait were running their own businesses, whilst one former caregiver in Taiwan was running a training institute for prospective caregivers to work overseas. A former nurse in Kuwait was working as a part-time homecare nurse. The last group includes those who were not working or running a business: one informant was studying for a bachelor's degree and the other was taking a break from work but planning to look for a job as a nurse.

Some of informants with a Diploma III before being deployed overseas continued their education to earn a bachelor's degree (S1) whilst working as a nurse. Higher education is needed to maintain and advance a nursing career since many hospitals require nurses to have at least a bachelor's certificate. Advanced education is funded by hospitals where nurses work, which is one reason why the informants were still studying at nursing schools whilst working in health facilities.

MG2 returned to work as a nurse. Before working abroad, she had worked as a nurse for 8 years in a private hospital in Jakarta whilst studying at a private nursing college for a bachelor's degree (S1), with funding from her employer.

MG3 started working as a nurse in a primary health clinic of the religious organisation that had sent him to work in Ethiopia. At the time of the interview, he was studying at a private nursing college in Jakarta.

MG1, whose husband and children were living in Papua province at the time of the study, returned home after completing her employment contract in Zimbabwe and was accepted as a government official nurse. She was working in a government hospital in the province.

Besides investing in property, MG5 was working part-time as a nurse for a foundation that provides home care services and was on call to care for expatriate patients.

The former caregiver who returned from Taiwan established and was managing a training institute for caregiving skills. She finished her bachelor's degree in Indonesia. Her employer asked her many times to return to Taiwan. Because demand for caregivers is high in Taiwan and other countries, she was intending to produce reliable caregivers who meet requirements to work abroad.

MG1 said that the work experience abroad of returning nurses who want to work in government hospitals is not considered. Instead, they start at level I, commensurate to their level of education.[7] Private hospitals have a similar system. MG2 said, fortunately, work experience abroad enables nurses to enjoy faster salary increases than those with no such experience. MG 9 and MG12, who had worked overseas, were promoted within 3 years of returning even though they had started at the lowest level.

One informant's work did not directly relate to nursing but to distribution of medical devices. He had planned the business whilst working as a nurse in Singapore and observing the hospital's advanced and modern equipment. He was earning much more than he would as a nurse.

4.6. Improved Skills from Working Abroad: Capital for Future Work

Generally, by improving their nursing and other skills abroad, Indonesian nurses gain benefits that further enhance their work performance. Proficiency in the local language and English is an important skill gained by those who work as nurses or caregivers. Better clinical nursing skills, mainly related to duties in related departments, are gained by those who work as nurses at hospitals. Nurses who worked as nursing assistants, however, did not see any skills improvement. Those who worked in Japan, for example, were not permitted to perform medical actions and were supervised by Japanese nurses until they passed the Japan national examination (Mutiawanthi, 2017).

Migrant nurses improve skills not related to clinical nursing, such as communication and negotiation, knowledge of different work systems and cultures, ability to work systematically, self-development such as increased self-confidence, amongst others. Nurses working as caregivers learn only practical skills in caring for the elderly since they are not allowed to perform medical or nursing interventions. Thus, they are deskilled, unable to practice the clinical nursing skills learnt in Indonesia.

[7] Regulation of the Minister of Health Number 40 of 2017 concerning the Development of Professional Career Paths for Clinical Nurses (https://peraturan.bpk.go.id/Home/Details/112121/permenkes-no-40-tahun-2017)

Skills improvement and work experience are non-money returns on investment, human capital enabling migrant nurses to get better jobs when they return to Indonesia or return to work abroad. Still, they have problems finding rewarding jobs (Mujiati and Hendarwan, 2019).

The study found that after returning to Indonesia, nurses usually (i) return to nursing work, (ii) change jobs, or (iii) stop working. Of the 12 informants who had worked abroad, 7 continued working as nurses after returning to Indonesia. Amongst the nurses who had worked as caregivers abroad, two returned to work as nurses in Indonesia. However, work experience and skills improvement gained abroad do not necessarily translate to better opportunities at home. Some returnees must restart their careers from scratch. MG1 returned to Indonesia after working in Zimbabwe for 2 years and was hired as a nurse in a government hospital in her hometown. She continued her education to obtain a bachelor's degree in nursing under the sponsorship of the hospital where she was working.

Of the 12 informants, 6 continued their nursing education after returning to Indonesia whilst 1 was planning to do so.

The study found that low salaries and lack of social protection are factors that prevent returned nurses from working as a nurse in Indonesia; they prefer better-paying jobs. MG5 chose to study for a bachelor's degree in nursing, since he had saved money from working abroad. He planned to run a private nursing training centre in his hometown after finishing his education. MG5 said that work experience of nurses abroad does not have any impact on better working class or rank when they return to work as nurses.

Private hospitals consider work experience in calculating nurses' salary. MG2 worked as a nurse in a private hospital in Indonesia and then for 3 years as a nurse in Japan. Upon returning, she was accepted at a private hospital as a general nurse, the lowest level. She said, however, that she could negotiate her salary based on her experience abroad.

MG3, a 38-year-old male nurse who worked in Ethiopia for 4 years, said that his work experience was considered there as capital related to his expertise. He did not have to start from scratch after changing jobs, but only if the job was the same, as a nurse in the same country. Not so in Indonesia, he said, where returning nurses must start from 'zero'.

The experience and skills gained abroad can be capital for other jobs. MG4 did not work as a nurse after returning to Indonesia but used the knowledge he gained working as a nurse in Singapore to build his own business.

MG7, who used to work as a caregiver in Taiwan, was running a training institute for prospective caregivers. After returning to Indonesia, she earned an S1 degree and declined offers to return to work in Taiwan because she was teaching at the private Nursing Education Institution (Lembaga Pendidikan Keperawatan-LPK), aside from family reasons. Finally, she quit teaching to establish a nursing education institution that trains care workers who intend to work abroad, especially in Taiwan.

Former migrant nurses did not think their overseas work experience would help them obtain better jobs in other countries, possibly because it had not resulted in transferable skills, including in language and patient care. For example, an Arabic language certificate would not be useful in English-speaking countries.

5. Conclusion

Indonesian nurse migration can be seen as an investment since it has money and non-money returns. Money return is the income nurses receive from working abroad, which is much higher than what they would receive working domestically. This income can cover the cost of migration, maybe even the cost of nurse education (investment) in Indonesia. The non-money return from this investment is improved skills gained from work experience, on-the-job training, and training related to work.

This study shows that improved skills gained by Indonesian nurses whilst working abroad as nurses or caregivers cannot immediately be considered capital when they return to work as nurses domestically or as nurses or caregivers abroad. After returning to Indonesia, experience as a nurse or caregiver abroad does not have a direct impact on career advancement because the returning migrants must start their career from scratch, especially at government hospitals. Indonesian nurses who work abroad are often deskilled, which hinders them from re-entering the nursing profession in Indonesia.

Some improved skills open up work opportunities outside the nursing profession, allowing nurses to develop and run businesses that can be more profitable and provide a better income than a nurse's salary. Therefore, they prefer to leave the nursing profession and work in fields supported by their new expertise but still related to their expertise as health workers. Using their improved skills as capital to return to work abroad is also a problem for returning Indonesian nurses because the skills are not always transferable to other countries. To return to work abroad, they must take exams in the destination countries.

Policy Implication

The improved skills of Indonesian nurses working abroad are expected to increase their work productivity and effectiveness, which can improve their future work and provide health services to the community. However, this study shows that skills improvement amongst Indonesian nurse returnees is less rewarding in terms of career advancement and being useful to the community. Those who return to the nursing profession struggle on their own to improve their nursing skills by continuing their education. Cases abound of nurse returnees leaving their profession and choosing jobs that provide better economic benefits, rendering the investment in nursing education useless, which was not cheap. Some policies that could be considered to improve this condition are as follows:

(i) The government could provide support to nurses returning from working abroad to refresh their nursing skills, as some (especially those who worked as caregivers) have been deskilled, hindering their return to the nursing profession.
(ii) The government could develop a method of measuring the skills of nurse returnees based on the experience and training they obtained abroad, to set the minimum standards of rank or class of job and salary.
(iii) The government could facilitate the distribution and placement of former overseas nurses in areas that lack nurses (referring to the target ratio of nurse and population), since they are trained health personnel. Incentive schemes need to highlight and reward nurses who are willing to work in understaffed areas, which are generally areas far from city centres and the government centre.

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Appendix

Table 6A.1: Informants: Nurses and Caregivers Who Had and Had Never Worked Abroad

No.	Informant ID/Age/Sex/Current job	Highest educational level	Last working place abroad	Last occupation abroad	Duration of working abroad	Main reason to work abroad	Main reason to return to Indonesia
1.	MG1/43/F/Works as a nurse at a government hospital	Bachelor of nursing	French NGO Zimbabwe	Manager, programme on advocacy for HIV prevention in clinics and hospitals	2006–2007	Get experience	Finished working contract
2.	MG2/41/F/Works as a nurse at a private hospital	Diploma of nursing	Hospital in Japan	General nurse	2008–2011	Get experience	Family reason (getting married and looking after sick and aged father)
3.	MG3/40/M/Works as a nurse at a privately owned clinic	Diploma of nursing	Ethiopia Health Center, Ethiopia	Nurse at intensive care unit	2011–2013	Assigned by Catholic Church	Assigned by employer to return to Indonesia
4.	MG4/49/M/Works as product manager with a medical device supplier	Diploma of nursing	Hospital in Singapore	General nurse with special task on neuro care	2002–2006	Get experience	Finished working contract, after being extended for 2 years
5.	MG5/44/M/Works as a freelance home care worker and runs a rental house business	Bachelor of nursing	Psychiatric hospital, Kuwait City	General nurse	2003–2015	Earn higher salary	Family reason (to look after aged mother and feeling homesick)
6.	MG6/55/F/Continuing nurse education; planning to work after finishing education	Diploma of nursing	Government hospital, United Arab Emirates	General nurse; deputy section chief (latest position)	1997–2017	Earn higher salary	Family reason (aged parents) and because management change in hospital, higher educational qualification now required for position as supervisor

7.	MG7/35/F/Runs a private training institution for caregivers who intend to work abroad	Bachelor of widwifery; continuing education after returning to Indonesia	Nursing home, Taipei, Taiwan	Caregiver at nursing home	2008–2011	Earn and save money for further education	Saving is sufficient for further education in Indonesia
8.	MG8/30/F/Does not work	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	Dental clinic, Najran, Saudi Arabia	Dental general nurse	2015–2018	Earn higher salary	Finished working contract
9.	MG9/32/F/ Works as a nurse at a government hospital	Bachelor of nursing	Nursing home, Jepang, Indonesia	Caregiver	2013–2015	Earn higher salary and save money to improve economic life of family	Finished working contract
10.	MG10/48/F/Works as a nurse at a private hospital	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification	Medical Centre, Amsterdam, Netherlands	General nurse	1999–2001	Earn higher salary and save money	Finished working contract
11.	MG11/58/F/ Works as a nurse at a private hospital	Bachelor of nursing, with additional 1 year nursing	Hospital, Los Angeles, California, USA	Student worker (sent by working place to a hospital in Jakarta)	1999–2001	Career development, increase nursing science knowledge	Finished period of study and duty abroad

		education for achieving professional nurse certification					
12.	MG12/30/F/Works as a nurse at a government hospital	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification.	Nursing home, Jepang, Indonesia	Caregiver at nursing home	2013–2015	Earn higher salary	Finished working contract

A. Nurses and Caregivers Who Never Worked Abroad (but are working)

No	Informant ID/Age/Sex	Highest educational level	Last occupation (in Indonesia)	Duration of work (all work)	Intention to work abroad
1.	NMG1/44/F	Diploma of nursing	Head of Private Eyes Poly Clinic, Jakarta	Since graduating in 1998, still working in the health sector (nurse)	Wants to change fate Already registered and prepared to depart but failed because parents denied permission to work abroad
2.	NMG2/40/F	Diploma of nursing	General nurse at a private acupuncture clinic, South Tangerang, Province of Banten	Since graduating until now, still working as nurse but thrice changed working place	None
3.	NMG3/40/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse at (NICU/PICU), at a private hospital, Jakarta.	Since graduating in 2001 until now, still working as nurse	More professional status working abroad, better welfare
4.	NMG4/25/F	Bachelor of nursing, with additional 1 year nursing education for achieving	General nurse, at a government hospital in Jakarta	Since graduating in 2016 until now, still working as nurse	More appreciation for nurses, proportional workload, certainty of legal protection

		professional nurse certification (STR)			
5.	NMG5/31/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse, at a private hospital in Jakarta	Since graduating in 2002 working as nurse	Higher salary and appreciation, better opportunities to improve skills and education
6.	NMG6/32/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse at adult ward, at a government hospital in Jakarta	Since graduating in 2014 working as nurse	None. Family does not allow her to work-abroad. Wants job close to parents
7.	NMG7/40/M	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse at intensive care unit (ICU), at a private hospital in Jakarta	Since graduating in 2001 working as nurse	None
8.	NMG8/55/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General Nurse, (haemodialysis), at a private hospital in Jakarta	Since graduating in 1985 working as nurse	None
9.	NMG9/31/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse at intensive care unit (ICU), at a private hospital in Jakarta	Since graduating in 2010 working as nurse	To increase skills and experience
10.	NMG10/42/F	Bachelor of nursing, with additional 1 year nursing education for achieving professional nurse certification (STR)	General nurse, at a private hospital in Jakarta	Since graduating in 2002 working as nurse	None

Note: MG, migrant refers to a migrant nurse or caregiver informant who had worked abroad. MG6 means migrant informant number 6.
NMG , non-migrant, refers to a nurse and caregiver informant who had not experienced working abroad. NMG1 means non-migrant informan number 1 (Appendix).
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