Movement of Natural Persons in Japan's EPAs: Cases of Health-care Providers

Joon Heon Song

School of Business and Commerce, Tokyo International University, and
WTO Research Center, Aoyama Gakuin University, Japan

ABSTRACT

In September 2006, Japan signed an Economic Partnership Agreement (EPA) with the Philippines in an effort to establish the East Asian Community. The Japan-Philippines EPA (JPEPA) has great meaning because it includes a provision that grants entry into Japan to Filipino nurses and care workers who met certain requirements. In fact, Japan has not allowed the entry of foreign unskilled workers, although the government has encouraged the immigration of highly-skilled personnel. The JPEPA was the first bilateral agreement in which Japan allowed foreign workers in new occupations to qualify for resident status. Moreover, as a result of the precedent set by the JPEPA, the Japanese government had to accept similar requirements in EPA negotiations with Indonesia, Vietnam, and India. According to the EPAs, Japan accepted 1,360 nurses and care workers from the Philippines and Indonesia during the period of 2008 to 2011. Although international movement of natural persons is caused by political, economical, social, legal, historical, and cultural factors, extant research has focused on the pull and push factors represented by the economic asymmetry of both the sending and receiving countries. However, it is undeniable that the acceptance of foreign health-care providers through the EPAs is an outcome of political negotiations. In this paper, I have three objectives: (1) to simply describe the factors affecting international movement of labor, (2) to examine the provisions regarding the movement of natural persons in Japan's EPAs with focus on health-care providers, and (3) to discuss the problems and issues regarding the acceptance of foreign health-care providers in Japan.

Keywords: *Economic Partnership Agreement, movement of natural persons, nurses and careworkers, Japan*

I. Introduction

The international migration of health-care providers is not a new phenomenon. According to World Health Organization (WHO, 2010), of the 60 million health-care workers worldwide, many migrate to developed countries for higher income, job opportunities, high quality of living standards, professional development, personal safety, and so forth (Kingma, 2007). For example, a total of 12,082 nurses left the Philippines, the largest exporter of nurses, to work abroad in 2010 (POEA, 2011). Because the international migration of health-care providers has become increasingly visible, it is often pointed out as one of the main causes behind these shortages (OECD, 2010).

While many developed countries facing workforce shortages have increasingly turned to aggressive foreign worker recruitment from developing countries (Brush & Sochalski, 2007), Japan has the most restrictive exclusion policy regarding foreign workers among all industrial countries (Corning, 2007). As of the end of 2010, the number of registered foreign nationals was about 2.13 million, accounting for merely 1.67% of the total Japanese population (MOJ, 2011). Further, looking at the statistics of registered foreign nationals by status of residence, the number of those with the status of "medical services" that is, physicians, dentists, nurses, and other legally qualified people who engage in medical treatment services was only 265 during the same period.

In principle, the Japanese government has not allowed the entry of foreign unskilled workers because of worries about the negative impact, such as increases in social cost, deterioration of public peace, and classification of social structure (Yamamoto, 2009). It has been Japan's basic policy that the government encourages only the immigration of highly skilled personnel, such as engineers and academics, since the Sixth Basic Plan for Employment Measures approved by the Cabinet meeting in 1988.

However, in September 2006, Japan signed an Economic Partnership Agreement (EPA) with the Philippines and granted entry to Filipino nurses and careworkers who met certain requirements. Prior to the EPA, foreign nurses who graduated from Japanese nursing schools were eligible for four years of on-the-job training in Japan, and careworkers were not permitted to work in Japan at all (Corning, 2007). Although the shift in policy is partially related to social problems such as the aging population and low birth rate in Japan (Sugawara, 2007), the acceptance of foreign health-care providers through the EPA is

essentially an outcome of political negotiations (Song & Song, 2011).

The term EPA refers to an economic arrangement on the liberalization of trade, which includes matters concerning the free movement of services and investment between member countries. Inevitably, almost all EPAs include provisions on the movement of natural persons for example, short-term business visitors, intra-corporate transferees, and investors. However what needs to be emphasized is that the Japan-Philippines EPA (JPEPA) was the first bilateral agreement in which Japan allowed foreign nurses and careworkers in new occupations to qualify for resident status. As a result of the precedent set by the JPEPA, the Japanese government had to accept similar requirements in EPA negotiations with Indonesia, Vietnam, and India.

This paper is prompted by the need to provide information and ideas for discussion on the movement of natural persons, with a focus on the health-care providers in Japan's EPAs. The rest of this paper is organized as follows: the second section reviews the factors of international migration, especially in the light of health-care providers; the third section examines the provisions regarding the acceptance of foreign nurses and careworkers in Japan's EPAs, and, based on this analysis, the final section of this paper discusses the problems and issues regarding the acceptance of foreign health-care providers in Japan.

II. International Migration Factors

Broadly defined, the act of migration means a permanent or semi-permanent change of residence (Lee, 1966). More specifically, international migration refers to crossing the frontiers that separate one country from another, whereas internal migration means a move from one area to another within one country. In terms of controlling international migrants by states, they can be categorized as follows: temporary migrants, highly skilled migrants, irregular migrants, refugees, asylum-seekers, forced migration, family members, and return migrants (Castles, 2000). According to Lee (1966), no matter how short or how long, how easy or how difficult, every act of migration involves an origin, a destination, and an intervening set of obstacles.

Although various migration theories have been developed over many years, there is no single and coherent theory to explain the factors that produce and promote international migration (Massey *et al*., 1993; Kingma, 2007). International migration is not only an integral part of globalization, but it is also a result of the interplay of political, social, economic, legal, historical, cultural, and educational factors. While international migration occurs for a variety of reasons, three distinct perspectives have been used to analyze the mobility of health professionals (Bach, 2007).

The neoclassical economic perspective, probably the oldest and best-known theory of migration, suggests that migration flow is caused by geographic differences in the supply of and demand for labor (Massey *et al*., 1993). This equilibrium approach assumes that individual rational actors decide to migrate based on cost-benefit calculation and ease of mobility. The neoclassical theory is often expressed as the "push-pull theory" because international migration is caused by sending countries' push factors as well as the receiving countries' pull factors (Castles & Miller, 2009). As Kline (2003) points out, many nurses migrate to seek better wages and working conditions than they their native countries can provide. In the case of Filipino nurses, low salary, work overload or a stressful working environment, limited opportunities for employment, and socio-political and economic instability are notable examples of push factors. By contrast, examples of pull factors include high income, the opportunity for family to migrate, advanced technology, and so forth (Lorenzo *et al*., 2007).

Next, household and network approaches, a new economics of migration, suggests that migration decisions are not made by isolated individuals, but rather by larger units of related people that is, families or households (Massey *et al*., 1993). The decision to migrate may be influenced not only by the international wage differentials, but also by family wealth or social networks (Stilwell *et al*., 2004). The possibility to offer a better or safer future to their children may also be a determinant (OECD, 2010). From the Philippines' perspective, the migration culture or links to the diaspora has generated the international migration of nurses and careworkers (Castles & Miller, 2009). According to this approach, households use international migration as a means of minimizing risks and overcoming a variety of market failures. By sending members abroad to work, households can diversify their labor portfolio to control risks stemming from uncertainty such as unemployment, crop failures, or commodity price fluctuations (Masey, 1999). However, the role of households and families has been a less prominent feature of studies of nurse mobility because of formal licensing requirements and limited job opportunities compared to the unskilled workers (Bach, 2007).

Finally, the globalization approach linked to the historical-structural tradition argues that international migration is a consequence of the globalization of the market economy. As Castles (2000) points out, migration is a result of the integration of local communities and national economies into global relationships. According to this perspective, the unequal distribution of economic and political power is the main cause of migration (Castles & Miller, 2009). As a result, international migration is inevitably generated in the process of capitalism to mobilize cheap labor from one country to another. The emphasis on the inevitability is routinely used as an explanation for global nurse migration (Bach, 2007).

While the above studies provide important insights to understanding the causes of international migration, the importance of the role of the state has largely been ignored. State interventions undoubtedly influence international migration, though the decision to migrate is essentially a personal one (Massey, 1999; Stilwell *et al*., 2004). Because the state plays a key role either in promoting or limiting international migration, state policy in both receiving and sending countries is crucial for migrant flows and patterns (Bach, 2007). Actually, it is one reason why the Philippines became the world's leading exporter of professional nurses (Brush & Sochalski, 2007; Lorenzo *et al*., 2007) and why Japan has had a homogeneous nurse workforce (Kline, 2003).

As Kingma (2007) points out, there are several significant barriers for nurses who consider migration, such as the process of requalification, the cost of a physical transfer, the need to learn a new language, adapting to different clinical practices, and time-consuming as well as costly immigration procedures. Specifically, the mobility of health-care workers is influenced strongly by the regulatory frameworks of governments (Bach, 2007).

Government regulations can be broadly grouped into the following four categories: (1) immigration-related regulations governing entry and stay; (2) regulations concerning recognition of qualifications, work experience, and training; (3) differential treatment of domestic and foreign personnel; and (4) regulations on other modes of supply (Chanda, 2001). While the main restriction on movement of natural persons stem from immigration or the government's labor market policies, regulations included in the second category are common in fields requiring accreditation such as law, accounting, and health-care.

III. Movement of Natural Persons in EPAs

1. Overview

Recently, bilateral or regional trade agreements (RTAs) have increasingly expanded their scope to include the movement of natural persons, including health-care providers. For example, some RTAs, such as the North American Free Trade Agreement (NAFTA), the European Union (EU), and the Caribbean Community and Common Market (CARICOM), have expanded nurse migration among the member countries (Kingma, 2007). Chapter 16 of the NAFTA contains provisions on the movement of natural persons for more than sixty categories of professions, including the medical/allied professional such as the dentist, physician, psychologist, and registered nurse. The EU has devised a scheme to encourage first-level registered nurses or midwives to work in any other EU member states. Protocol II of the CARICOM also has promoted the intra-regional movement of skilled workers such as nurses.

Of course, the General Agreement on Trade in Services (GATS) of World Trade Organization (WTO) also includes several provisions and general disciplines on the movement of natural persons, from high-level engineers to unskilled workers. However, although the GATS has laid down a set of legally enforceable rules stipulating the movement of natural persons, negotiations to facilitate the employment of foreign health-care providers have not progressed (Kingma, 2007). Mode 4 of the GATS particularly focuses on the provision of health services by individuals from another country on a temporary basis (Stilwell *et al*., 2004), and many member countries have made only horizontal commitments (METI, 2010). Japan, for example, has made horizontal commitments in only three areas: intra-corporate transferees, professional services, and temporary stays. The possible impact of the GATS on health-care services is still controversial (Stilwell *et al*., 2004).

In contrast to the multilateral negotiations, RTAs can facilitate movement of health-care providers in various ways. For example, the provisions of the NAFTA encourage the movement of nurses by removing the economic need test (Blouin, 2005). In the case of CARICOM, skilled professionals can work overseas on a rotational basis, going for three years or so and then returning (Stilwell *et al*., 2004). The provisions of the RTAs concerning the movement of natural persons can be classified into four types: (1) those regulating the general movement of natural persons, including the entry or permission to acquire status of residence; (2) those permitting the movement of natural persons to the extent necessary for the liberalization of investment and services; (3) those similar to the GATS Mode 4; and (4) those simplifying only immigration procedures (Tojo, 2007).

This diversity is explained not only by the nature of the RTAs, such as geographic proximity, similarities in levels of development, and cultural and historical ties, but also by the extent to which the contracting parties aim to achieve the goal of the RTAs. Moreover, the provisions on movements of natural persons reflect the complex intertwining of both migration and trade policies (Tojo, 2007).

2. Japan's EPA

Since Japan finalized an EPA with Singapore in 2002 for the first time, the Japanese government has actively engaged in EPA negotiations, particularly with East Asian countries. As of September 2011, Japan had EPAs in effect with Singapore, Mexico, Malaysia, the Philippines, Chile, Thailand, Brunei, Indonesia, Vietnam, Switzerland, India, and ASEAN. A noteworthy characteristic of Japan's EPAs is economic cooperation covering a broad range of areas, including intellectual property, government procurement, temporary entry of business people, and customs facilitation (Solís, 2009).

In general, Japan's EPAs adopt the "GATS-plus" commitments regarding investors, in addition to short-term business visitors and intra-corporate transfer-

ees (Sugawara, 2007). Japan also agrees to the movement of natural persons who engage in professional services, such as lawyers, patent attorneys, maritime procedure agents, accountants, and tax accountants. Besides, Japan is making a commitment to accept natural persons who engage in business activities based on a personal contract with public or private organizations, such as engineers and specialists in the humanities or international services.

The most important part of this argument is that Japan approves the acceptance of health-care providers through EPAs with the Philippines, Indonesia, and Vietnam. Though the Japan-Singapore EPA does not include a chapter on the movement of health-care providers, the Japanese government made a verbal commitment to accept a maximum of seven doctors and two dentists if they take and pass Japanese national examinations for medical practitioners using the English language (METI, 2010). As mentioned above, the JPEPA was the first bilateral agreement in which Japan allowed foreign nurses and caregivers in new occupations to qualify for resident status. Moreover, as a result of the precedent set by the JPEPA, the Japanese government had to accept similar requirements in EPA negotiations with Indonesia, Vietnam, and India (Song & Song, 2011).

Annex 8 to Chapter 9 (Movement of Natural Persons) of the JPEPA contains provisions concerning the acceptance of Filipino nurses and careworkers to Japan, which includes the following: (1) obtaining a qualification as a nurse or careworker under Japanese law; (2) pursuing the course of training, including Japanese language training for six months; and (3) acquiring necessary knowledge and skills through the training under the supervision of *Kangoshi* (registered nurse) at the hospital for nurses or *Kaigofukushishi* (certified careworker) at the caregiving facility or training facility for careworkers. Filipino nurses and careworkers are officially referred to as "candidates" in Japan, because they are permitted to work as nurses and careworkers on passing the Japanese national examinations. Under the JPEPA, the candidates are given a maximum of three opportunities to take the national examinations for *Kangoshi* within three years.

Similarly, the Japan-Indonesia EPA (JIEPA) and Japan-Vietnam EPA (JVEPA) include provisions on the acceptance of health-care providers. In a manner similar to the JPEPA, the JIEPA also includes commitments to measures related to the acceptance of nurses and careworkers, excluding a facility training course for careworkers. Annex 10 to Chapter 7 (Movement of Natural Persons) of the JIEPA provides for the requirements for Indonesian nurses or certified careworkers or related activities via a personal contract with a public or private organization in Japan. In the case of the JVEPA, Japan grants entry and temporary stay to Vietnamese who have been qualified as a nurse under the laws and regulations of Japan to practice nursing for a period of one to three years, which may be extended within seven years from the date of obtaining a license of *Kangoshi*.

Additionally, according to Article 79 (Further Negotiations) and Annex 7 to Chapter 8 of the JVEPA, Japan agreed to enter into negotiations with Vietnam for possible acceptance of Vietnamese qualified nurses and certified careworkers within two years after the entry into force of the EPA. As a result, in October 2011, the Japanese government announced that Japan plans to accept Vietnamese nurses and careworkers in 2013 under the EPA. Japan is also negotiating with Thailand regarding the possibility of acceptance of Thai careworkers and spa therapists, and with India regarding the acceptance of Indian nurses and careworkers.

As of July 2011, a total of 569 Filipino candidates (209 nurses and 360 careworkers) and 791 Indonesian candidates (363 nurses and 428 careworkers) were accepted (MHLW, 2011). In fact, the Japanese government was planning to accept a total of 400 nurses and 600 careworkers from the Philippines and Indonesia, respectively, for the first two years after the entry into force of the EPAs. The number of foreign candidates for nurses and careworkers is smaller than expected, and some candidates have even returned home before the expiration date of the visa. Moreover, from 2009 to 2011, the number of foreign candidates who passed Japan's national nursing examination was merely 19, while the pass rate of Japanese was 91.8% in 2011. It is also difficult for foreign careworkers to pass the national examination because of language, cultural, and educational barriers.

IV. Discussion

Since the early 2000s, the acceptance of foreign health-care providers has been controversial in Japan. According to a poll by the Cabinet Office (2000), about 48.3% of respondents opposed receiving foreign workers because of inadequate communication skills, lack of knowledge about Japanese culture, fears about workers' incompetence, and unemployment of Japanese workers. Conversely, some people approve of the policy because of the shortage of health-care workers, globalization of Japanese nursing services, and contribution to international cooperation (Song & Song, 2011). Though social conflicts have not yet been solved, the program for acceptance of foreign health-care providers is increasingly evolving.

In November 2011, the Japanese government released a new Basic Policy on Comprehensive Economic Partnerships, which included the direction of Japan's EPA strategy. According to this policy, the Japanese government will promote domestic reforms in the agricultural industry, movement of natural persons from abroad to Japan, and regulatory reforms in order to strengthen high-level EPAs with major countries or regions. Specifically, the Japanese government will encourage the acceptance of foreign nurses and careworkers to promote the employment and

human resources strategies described in the New Growth Strategy.

To promote high-level EPAs within the Asia-Pacific region and broader regional economic partnerships, the Japanese government revised some regulations regarding the acceptance of foreign nurses and careworkers under the EPAs. For example, in March 2011, the Japanese government decided to extend by a year the stays of Indonesian nurses and careworkers who came to Japan in 2008 under the JIEPA to give them an extra chance to take the Japanese nursing examination. To avoid diplomatic conflicts with the Philippines and Indonesia, the government improved the regulations on the national examination for nurses and careworkers. In February 2011, the Ministry of Health, Labor and Welfare submitted a counter plan for raising the pass rate of the national examination, which included replacing difficult technical terms with easy and simple words and using a combination of English and Chinese characters.

So far, we have outlined the movement of natural persons in Japan's EPAs, with a focus on health-care providers. Although the EPAs encourage the acceptance of foreign nurses and careworkers, there are *de facto* barriers formed by regulatory requirements because the contents of the EPAs reflect a political compromise reached in negotiations between governments, bureaucrats, and interest groups (Song & Song, 2011). It is true that Japan's migration policy has not changed fundamentally; that is, the government has not allowed the entry of foreign unskilled workers. However, Japan will be confronted with continuous pressures to open up the labor market, in its pursuit of the goal of regional economic partnerships.

References

Bach, S. (2007). Going global? The regulation of nurse migration in the UK. *British Journal of Industrial Relations*, Vol. 45 (2), 383-403.

Blouin, C. (2005). NAFTA and the mobility of highly skilled workers: The case of Canadian nurses. *The Estey Centre Journal of International Law and Trade Policy*, Vol. 6 (1), 11-22.

Brush, B. L. & Sochalski, J. (2007). International nurse migration: Lessons from the Philippines. *Policy, Politics, & Nursing Practice*, Vol. 8 (1), 37-46.

Cabinet Office (2000). Survey on the problems of foreign labor. Retrieved May 19, 2011, from the Cabinet Office, Government of Japan Website: http://www8.cao.go. jp/survey/h12/gaikoku/index.html

Castles, S. (2000). International migration at the beginning of the twenty-first century: global trends and issues. *International Social Science Journal*, Vol. 52, 269-281.

Castles, S. & Miller, M. J. (2009). *The Age of Migration: International Population Movements in the Modern World*. 4th edition. New York: The Guilford Press.

Chanda, R. (2001). Movement of natural persons and the GATS. *The World Economy*, Vol. 24 (5), 631-654.

Corning, G. P. (2007). Japan's bilateral FTAs: No obstacle to progress in the Doha Round. *East Asia*, Vol. 24 (1), 45-67.

Kingma, M. (2007). Nurses on the move: A global overview. *HSR: Health Services Research*, Vol. 42 (3), 1281-1298.

Kline, D. S. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship*, Vol. 35 (2), 107-111.

Lee, E. S. (1966). A theory of migration. *Demography*, Vol. 3 (1), 47-57.

Lorenzo, F. M. E., Galvez-Tan, J., Icamina, K., & Javier, L. (2007). Nurse migration from a source country perspective: Philippine country case study. *HSR: Health Services Research*, Vol. 42 (3), 1406-1418.

Massey, D. S. (1999). International migration at the dawn of the twenty-first century: The role of the state, *Population and Development Review*, Vol. 25 (2), 303-322.

Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A., & Taylor J. E. (1993). Theories of international migration: A review and appraisal. *Population and Development Review*, Vol. 19 (3), 431-466.

METI (2010). Report on compliance by major trading partners with trade agreements-WTO, FTA/EPAs, BITs. Retrieved January 17, 2012, from the Ministry of Economy, Trade and Industry Website: http://www.meti.go.jp /english/report/data/gCT2010coe.html

MHLW (2011). Economic agreements and consultations. Retrieved January 7, 2012, from the Ministry of Health, Labour and Welfare Website: http://www.mhlw.go.jp/bunya/kokusaigyomu/keizaikyotei.html

MOJ (2011). 2011 Immigration control. Retrieved January 17, 2012, from the Ministry of Justice Website: http://www.moj.go.jp/nyuukokukanri/kouhou/nyuukokukanri06_00018.html

OECD (2010). International migration of health workers. *Policy Brief*, February 2010. Paris: Organization for Economic Cooperation and Development.

POEA (2011). Oversea employment statistics 2010. Retrieved January 18, 2012, from the Philippine Overseas Employment Administration Website: http://www.poea.gov.ph/stats/statistics.html

Solís, M. (2009). Japan's competitive FTA strategy: Commercial opportunity versus political rivalry. In M. Solís, B. Stallings, & S. N. Katada (Eds.), *Competitive Regionalism: FTA Diffusion in the Pacific Rim* (pp. 279-301). Hampshire: Palgrave Macmillan.

Song, J. H. & Song, J. H. (2011). Determinants of acceptance of foreign nurses and care workers in Japan (in Korean). *The Journal of Asiatic Studies*, Vol. 54 (3), 121-150.

Stilwell, B., Daillo, K., Zurn, P., Vujicic, M., Adams, O., & Poz, M. D. (2004). Migration of health-care workers from developing countries: strategic approaches to its management. *Bulletin of the World Health Organization*, Vol. 82, 595-600.

Sugawara, J. (2007). Problem of acceptance of foreign workers in terms of international trade: Movement of natural persons in WTO and EPA/FTA negotiations. Mizuho Policy Insight. Tokyo: Mizuho Research Institute.

Tojo, Y. (2007). Liberalization of movement of natural persons in regional trade agreements: A convenient framework of International cross-border labor mobility (in Japanese). RIETI Discussion Paper Series 07-J-008, Tokyo: Research Institute of Economy, Trade & Industry.

WHO (2010). Migration of health workers. Retrieved January 18, 2012, from World Health Organization Website: http://www.who.int/mediacentre/factsheets/fs301/en

Yamamoto, K. (2009). On the issues of the foreign nurse and caregivers (in Japanese). *The Quarterly of Social Security Research*, Vol. 45 (3), 258-268.