

The Case of Japan

How COVID-19 Impacted the Procurement and Lives of Migrant Healthcare Workers

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Abstract

This article offers an analysis of the impact of the severe acute respiratory syndrome coronavirus (SARS-CoV-2) pandemic in Japan with regard to the healthcare sector. With unprecedented pressure from a rapidly aging population, state-sponsored initiatives have created new migration streams from Southeast Asia, diversifying attempts to procure healthcare personnel to address labor shortages. The article analyzes the recent evolution of this supply chain nexus and how it was reconfigured during the pandemic. It also highlights the fragile dependency that Japan now has on an emergent nexus with surrounding countries and the strategies it has taken to ameliorate the vagaries of the ongoing pandemic.

Keywords: aging, care migrants, COVID-19, EPA, Japan, socioemotional commons

In Japan, a dynamic demographic shift toward a “super-aging society” has led to significant reconfigurations in Japan’s healthcare system and the procurement of skilled healthcare personnel. In response to this shift over the last twelve years, nurses and care workers from Southeast Asia have entered the workforce as part of a strategy to cover labor deficits. In early 2020, Japan’s dynamic societal context was severely affected by SARS-CoV-2 (henceforth COVID-19) that spread across Japan disrupting this newly emerging care nexus. A series of issues arise in this context, which constitute the research questions of this study: In what ways have transformations in the human supply chain been impacted? Has this led to a reorganization and reappraisal in the strategy to provision and provide care labor? How does this impact the development of social relationships between foreign workers and Japanese elderly persons? Does the pandemic provide us with a chance to observe societal changes in Japan? And will we, post-pandemic, see a reevaluation of the role of migrant labor? To answer these questions, we first situate and contextualize the impact of the pandemic in Japan. Second, we explain and identify the fragile dependency that Japan now has on migrant labor, and discuss how the pandemic has reoriented migrant flows, migrant relations, and perceptions of migrants’ caring for elderly people in Japan. Third, despite the extraordinary circumstances of the pandemic, we show that in some areas its impact has had



a potentially positive impact on reorienting the perceptions of migrant care workers' labor. Ultimately, we show that there may be a long-term role for migrants not just as temporary sojourners, but as potential citizens who can engage with ongoing societal and demographic shifts.

Demographic and Labor Market Transitions

Over the last twenty years, Japan has come to confront a massive demographic shift as it has transformed into a “super-aging” society. In 2020, over 65s accounted for 28.7 percent of the population, and this trend will only accelerate. The number will reach 32 percent by 2030 and around 41 percent by 2055. Presently, the total population of Japan stands at 126 million and is projected to significantly shrink to under 100 million by 2050 if the present trend does not change. By 2025, the so-called “Baby Boomer” generation will be 75 years or older and require significant medical and nursing care. As such, demographic contraction and aging have become a major public policy matter (Muramatsu and Akiyama 2011). With a low fertility rate (TFR 1.41), an ongoing decline in the birth rate will produce dynamic societal transformations in Asia's most industrialized nation. Neither a major change in policy toward fertility nor supplementary migration will ameliorate this decline in the population nor slow its aging (Parsons and Gilmour 2018). As a result of these complex shifts, labor shortages in the field of nursing care for the elderly in Japan have become a sensitive public policy issue. In 2016, the Japanese Ministry of Health Labor and Welfare (MHLW) announced that the number of nursing care personnel needed by the end of 2025 would stand around 2.33 million. By 2040, this is estimated to increase to 2.80 million. Increasingly, in urban areas employment security and the ratio of job openings in the nursing care industry have risen to high levels (MHLW 2019a, 2019b, 2019c, 2021b). In short, by 2025 there will be a shortfall of 550,000 more, or about 60,000 per year, which will rise to 690,000 by 2040 (see Figure 1).

Since 2000, a public long-term health care program (LTCI) has been in place to cover burgeoning medical expenditures, and this has led to the introduction of market-oriented care with private providers entering the care services sector. This quasi-market mechanism has diversified choices available to Japanese looking for care services (Hosono 2011). However, the introduction of this for-profit approach has not been able to cover the deficit of workers to support the elderly either through community-based care or through more traditional public social welfare providers. Care work in Japan has tended to be seen as low-status and low-wage work, resulting in a “care-provisioning” gap. In response to shortages, the Japanese government initiated a series of strategies that have deepened linkages with Southeast Asian nations. From 2008, nurses and care workers have started to enter Japan under Economic Partnership Agreements (EPAs) signed between Japan, Indonesia, the Philippines, and Vietnam (Hirano and Yoneyo 2021; Ohno 2012). This created an initial flow of highly

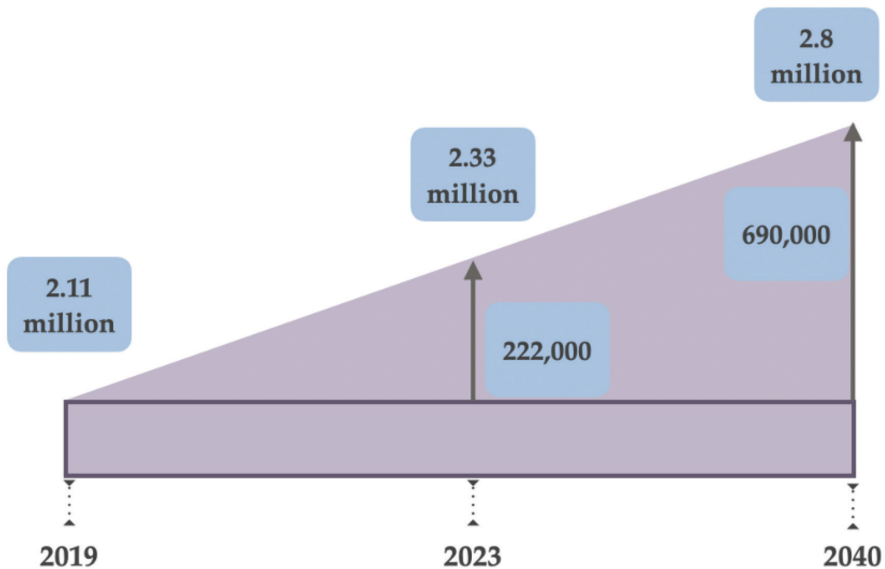


Figure 1. Required Number of Nursing Care Staff Based on the 8th Long-Term Care Insurance Business Plan (Source: MHLW 2021b)

skilled candidates for registered nurses and candidates for certified care workers who have entered Japan to work.¹ Under bilateral arrangements approved and managed by the Japanese International Welfare Corporation (JICWELS) and government agencies in sending countries between 2008 and 2019, 1,421 nurses and 5,063 certified care workers have entered the country as candidates² (see Table 1 and Table 2). However, the introduction of foreign healthcare personnel has done little to ameliorate the ongoing dual crisis of an aging society and a chronic labor shortage.

The new framework to bring in migrants to cover shortages in Japan's labor market is nothing new. The country has had an ambivalent relationship toward migrant labor since the 1980s, and from that time Japan, through different policies toward labor shortages, has seen a steady growth in the influx of foreign migrants, mostly from the wider Asia-Pacific Region and Latin America, coming to seek economic opportunities and safety. This has led to the settlement of new communities (Table 3). Migrant workers have often been treated as a temporary buffer workforce rather than as potential future citizens. In part, this is due to an ethnonationalist perspective that has long been a part of Japanese identity (Liu-Farrer 2020) and political sensitivity over opening Japan up to more permanent migrants with clear pathways to citizenship. As with a number of other nations in East Asia, Japan sees its foreign workforce as temporary, entering under restrictive policies that limit the flow of workers to specified industries (Peng 2017). Yet, since the late 2000s the ongoing dilemma of how to tackle a declining birth rate and burgeoning elderly population has led multiple administrations to

Table 1. Number of EPA Candidates for Registered Nurse Positions in Japan

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Indonesia	104	173	39	47	29	48	41	66	46	29	31	38	23
Philippines		93	46	70	28	64	36	75	60	34	40	42	49
Vietnam							21	14	18	22	26	41	38

Source: Japan International Corporation of Welfare Services (JICWELS)

Table 2. Number of EPA Care Workers Who Have Entered into Japan

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Indonesia	104	189	77	58	72	108	146	212	233	295	298	300	272
Philippines		190	72	61	73	87	147	218	276	276	282	285	261
Vietnam							117	138	162	181	193	176	193

Source: Japan International Corporation of Welfare Services (JICWELS)

eye migrants as carers as a part of a portfolio of strategies to alleviate labor shortages. In 2014, the Japanese government announced a revitalization strategy that included consensus on increasing care worker numbers under a technical training system (*tokutei gino seido*).³ Adopted revisions in 2017 allowed the entry of technical intern trainees in the area of care—predominantly from Asian countries—to shore up labor gaps through revised visa categories. These “nursing care students” were offered a pathway to becoming certified nursing care workers with “specified skills” (*tokutei gino*), and this has led to the diversification of migrants from across the region.⁴ Until 2020, there was a rise in foreign workers with the expectation that 60,000 persons from the region would fill gaps in the care labor market. Figures released by MHLW (2020a) show that the total number of foreign workers in Japan’s medical and welfare sectors rose to 43,446 by the end of October 2020, an increase of 9,185 over the previous year.

The COVID-19 Pandemic: Trajectory and Overview

In January 2020, the COVID-19 worldwide pandemic was first felt in Japan, when a Chinese national returned from the epicenter of the outbreak, Wuhan, China, and was confirmed as infected.⁵ However, it was infections onboard the Diamond Princess, a cruise ship from Hong Kong that arrived in the Port of Yokohama on 3 February, that brought the pandemic into clear focus. The entire vessel was placed in quarantine for sixteen days by which time 712 persons had been confirmed infected with thirteen reported deaths. From this point onward, subsequent confirmations of the spread of the virus in Japan led the former Japanese Prime Minister Shinzo Abe to announce plans to request the closures of all elementary and junior high schools from 2 March to the start of Japanese Spring Break (Golden Week). As part of its containment response, the government also ordered the establishment of a medical taskforce: the “Novel

Table 3. Registered Foreign Nationals by Country of Birth 1995–2020

Year	Total	Korean	Chinese	Vietnam	Brazilian	Philippines	Indonesian	Myanmar	Peru
1995	1,362,371	666,376	218,585	8,229	176,440	74,297	6,282	3,682	36,269
1996	1,415,136	657,159	222,991	9,009	201,795	84,509	6,956	3,643	37,099
1997	1,482,707	645,373	234,264	10,229	233,254	93,265	8,742	3,896	40,394
1998	1,512,116	638,828	252,164	11,897	222,217	105,308	11,936	4,232	41,317
1999	1,556,113	636,548	272,230	13,505	224,299	115,685	14,962	4,442	42,773
2000	1,686,444	635,269	294,201	14,898	254,394	144,871	16,418	4,669	46,171
2001	1,778,462	632,405	335,575	16,908	265,962	156,667	19,346	4,851	50,052
2002	1,851,758	625,422	381,225	19,140	268,332	169,359	2,083	5,080	51,772
2003	1,915,030	613,791	424,282	21,050	274,700	185,237	21,671	5,386	53,649
2004	1,973,747	607,419	462,396	23,853	286,557	199,394	22,862	5,600	55,750
2005	2,011,555	598,687	487,570	26,018	302,080	187,261	23,890	5,409	57,728
2006	2,084,919	598,219	519,561	32,485	312,979	193,488	24,858	5,914	58,721
2007	2,152,973	593,489	560,741	36,860	316,967	202,592	25,620	6,735	59,696
2008	2,217,426	589,239	606,889	41,136	312,582	210,617	27,250	7,789	59,723
2009	2,186,121	578,495	655,377	41,000	267,456	211,716	25,546	8,366	57,464
2010	2,134,151	565,989	680,518	41,781	230,552	210,181	24,895	8,577	54,636
2011	2,078,508	545,401	687,156	44,690	210,032	209,376	24,660	8,692	52,843
2012	2,033,656	530,048	674,879	52,367	190,609	202,985	25,532	8,046	49,255
2013	2,049,123	526,578	652,595	72,256	185,694	206,805	27,214	8,600	48,995
2014	2,086,603	508,561	647,310	85,499	177,953	213,923	30,210	10,252	48,263
2015	2,172,892	497,707	648,734	124,820	173,038	224,048	35,910	13,737	47,800
2016	2,307,388	456,917	656,403	146,956	176,284	229,595	42,850	17,775	47,670
2017	2,471,458	452,953	677,571	262,405	185,967	260,553	49,982	22,519	47,861
2018	2,637,251	452,701	711,486	330,835	196,781	271,289	56,346	26,456	48,266
2019	2,829,416	451,543	741,656	411,968	206,886	282,798	66,860	32,049	48,517
2020*	2,885,904	426,908	778,112	420,415	208,538	279,660	66,832	35,049	48,256

*Data for 2020 are valid to December 2020.

Coronavirus Expert Group” (*Shingata Korona Uirusu Kansenshō Taisaku Senmonka Kaigi*) under the Japanese Cabinet. As with other nations, public health measures (non-pharmaceutical interventions or NPIs) were deployed in the form of three regional and national lockdowns,⁶ restrictions on international and domestic movement, and the strengthening of quarantine measures and border controls. In early March 2020, the taskforce put forward the “3Cs” (*mitsu no mitsu: mippei, mishu, misetsu*). These are the “avoidance of three overlapping conditions” that encourage transmission: avoiding closed spaces, densely packed places, and close physical contact.⁷ As the pandemic progressed, the Tokyo Olympic Games were officially postponed for one year, and by early April a state of emergency was declared in seven prefectures,^{8,9} which subsequently extended across the nation and was in place until 14 May 2021.

These emergency declarations were subsequently relaxed but remained in place for eight priority prefectures. During this time, the controversial decision was taken to apply travel restrictions to eighty-nine nations, prohibiting entry to any persons who had traveled to those countries within fourteen days. This extended to those holding permanent residence status (*eijusha*), with only Japanese nationals and those with special permanent residence status (*tokubetsu eijusha*) allowed entry.¹⁰ While monitoring the situation, over May and June, the Tokyo Metropolitan Government (TMG) introduced an alert system, limited to the metropolitan area, to warn the public of infections. In response to infection rates, requests were made to retail businesses to curtail opening hours and to other businesses to close their offices. Osaka Prefecture, the second-largest urban area in the Kansai Region, created its own “Osaka Model” using a series of indicators and standards for judging both the spread and containment of daily infections through a color-based system to warn of the severity of infections.¹¹ After the initial first and second waves, the Japanese Office for Countermeasures to Combat the Novel Coronavirus (2020) announced on 7 August a series of indicators and guidelines with four clear stages.¹² Concurrently, in August, to respond to a lack of inbound tourists into the country and to the damage done to the economy, the government initiated the “Go To Campaign” aimed to run until spring 2021 and support an ailing tourism industry through discounts on hotels and the usage of coupons. However, this was suspended on 28 December 2020 due to concerns that it was facilitating the spread of the virus and worsening the epidemiological context by placing a burden on hospitalizations in some prefectures.¹³

Over the course of the last year, five infection waves were clearly visible. In line with the above-mentioned guidelines, the government has provided detailed real-time updates on medical care and bed occupancy.¹⁴ At time of writing, 13 per 100,000 were infected, and to date (as of 12 September 2021), deaths from the disease are the highest in East Asia at 18,036 (Figure 2) (Johns Hopkins Coronavirus Resource Center 2021; MHLW 2021a; NID 2021). The mortality rate stands at 1.05 percent (Figure 3). The spread of the Delta variant has placed the medical system under intense pressure, leading to high bed occupancy. In response to this problem, the MHLW Headquarters for the Promotion of Countermeasures for Coronavirus set guidelines for people with mild illness to stay at home and convalesce due to the pressure being put on hospital bed availability (see MHLW 2020c). This measure has been severely criticized due to the deaths of several people who stayed at home. In comparison to those of other industrial nations, the vaccination program was stymied by a slow rollout, which initially focused on medical workers and then the elderly population. As of 1 September 2021, 74.3 percent of the population had received one vaccine dose and 65 percent had received two doses (Figure 4). The Pfizer/BioNtech vaccine was approved on 30 April 2021, followed by emergency approval for the Moderna and AstraZeneca vaccines on 21 May. Within this unstable and yet-to-end national situation, we turn to how this has impacted the procurement of foreign healthcare workers, and provide preliminary field data on the impact of the pandemic on everyday working relations.

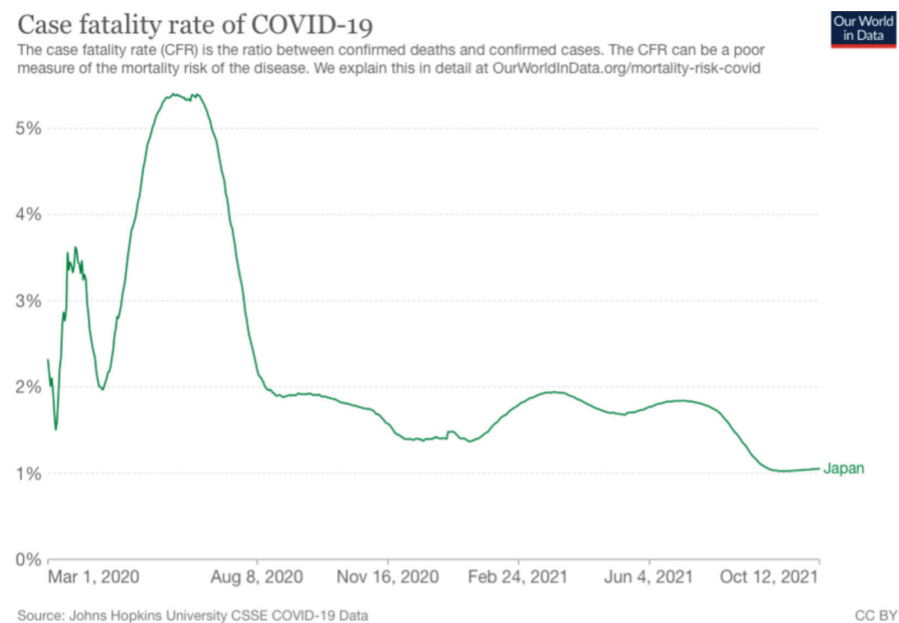


Figure 2. Mortality Rate for Japan: 1 March 2020 – 12 October 2021

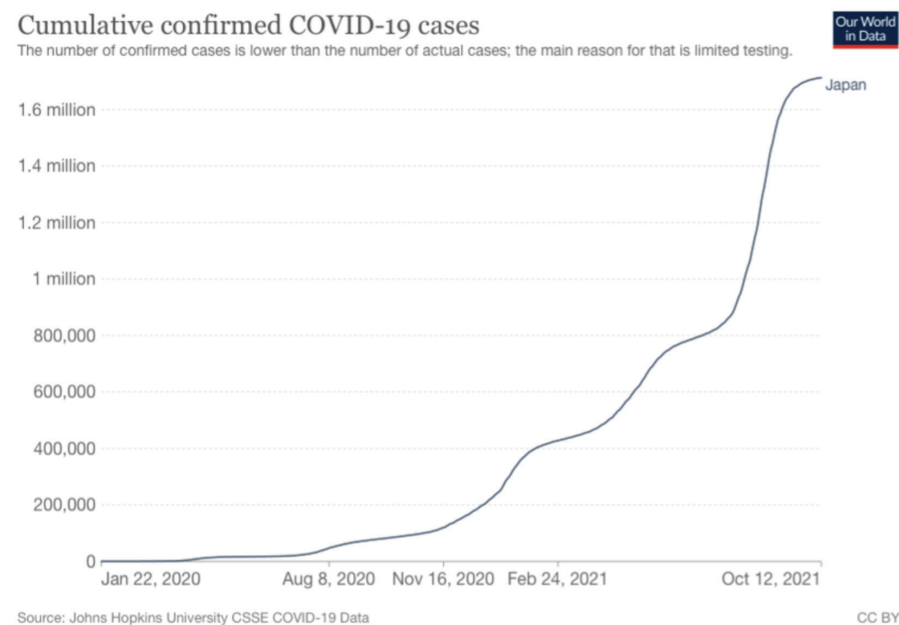


Figure 3. Cumulative Confirmed Deaths: 1 March 2020 – 12 October 2021

Share of people who received at least one dose of COVID-19 vaccine

Total number of people who received at least one vaccine dose, divided by the total population of the country.



Source: Official data collated by Our World in Data.

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Figure 4. Cumulative Number of Persons Vaccinated Domestically: 17 February 2021 – 12 October 2021

Research Methodology

To verify how the coronavirus has affected migrant workers, their employers, and the quality of social care the former provide, research was conducted between April 2020 and October 2020 in Osaka, Chiba, Kyoto, and Fukuoka Prefectures. We aimed to observe how the pandemic created a space to inquire into societal transformation in the sphere of provisioning care. Research focused on interviewing recruitment agency suppliers (two persons); recruitment organizations and educational facilities (three persons), care home managers (four persons); private training schools (two persons); civil servants (two persons); EPA-certified care workers (four persons) and candidates (1 person); technical intern trainees (ten persons); foreign students under training and working schemes (four persons); and those without certificates (four persons). These persons and organization representatives were interviewed so that we could paint a picture of the transformations that occurred over the last fifteen months (total of thirty-six interviewees).¹⁵ All interviews were recorded and transcribed into Japanese, and then relevant sections were translated into English. For this article, we mainly focus on the situation in Fukuoka Prefecture, on the island of Kyushu, in southern Japan. This area was chosen for two reasons. First, it has some of the worst shortages in the care sector and had seen a significant increase in the number of technical intern trainees and foreign students in recent years. Second, this is a research site

we have both worked at for over fifteen years, and we have a significant network of contacts there. Research for this article was limited due to domestic and institutional travel restrictions. Our face-to-face interviews were conducted between the second and third waves, a time when domestic travel was allowed.¹⁶ The interviews and questions focused on analyzing how workplace relations changed between foreign staff, their employers, and their relations with the elderly in their homes so as to clarify whether any changes to institutional care had taken place.

Findings

Reorienting Labor Supply Chains for the Healthcare Sector

Since 2008, the Philippines, Indonesia, and Vietnam have been sending candidates for certified care worker positions and candidates for registered nurse position to Japan. This has permitted entry to graduates of three- or four-year nursing schools in their home countries in accordance with the criteria set under the EPAs. To date, 1,598 out of 5,063 care worker candidates have passed the national examinations for care workers by the end of March 2021 to obtain qualifications to work (MHLW 2021b).

EPA candidates are scheduled for arrival every spring; however, the closure of Japan's borders to foreign nationals in 2020 has significantly delayed dispatches from each country. Notwithstanding this delay, some candidates have been able to enter when restrictions were relaxed. From Vietnam, where coronavirus infection rates have been among the lowest in the region, 193 care worker candidates arrived in Japan in early November along with 38 registered nurse candidates; from Indonesia, between mid- to late December, 280 care worker candidates and 23 nurse candidates arrived; and 310 candidates (261 care worker and 49 nurse candidates) due to arrive in 2020, arrived late from the Philippines between May 25–27, 2021.¹⁷ Even during the pandemic, which has made international travel difficult, the urgent need for sending and receiving EPA nurses and care workers has not abated.

Between January 2018 and March 2020, the nursing care industry accepted technical interns from Vietnam, Myanmar, China, and other Asian countries. The organization charged with coordinating trainees, the Organization for Technical Intern Training (OTIT), showed that the number of foreign technical interns receiving training in the nursing care field stood at 8,967 (JITCO 2020). In effect, this accounted for 2.4 percent of all interns present in Japan (366,167). Prior to the pandemic, the reorganization of labor streams meant that the number of nursing care trainees visiting Japan had exceeded the total number of trainees accepted under the EPA programs. By nationality, the largest number of trainees comes from Vietnam (3,523), and they account for 40 percent of the total number of nursing care trainees, followed by nationals from other countries in Southeast Asia and East Asia (Table 4).

Table 4. Number of Certified Specified Skills Work by Nationality for the Care Work Sector (Percent of Total)

	2017	2018	2019
Total	63,627	389,321	366,167
Vietnam	0	653	3523
Myanmar	0	258	1486
Indonesia	0	322	1423
China	0	320	1173
Philippines	0	13	615
Mongolia	0	70	254
Cambodia	0	99	155
Thai	0	26	82
Other	0	62	256
%	0	0.5%	2.4%

Source OTIT: 2019, 2020

For jobs within industries that accept technical interns, the training period necessary to obtain Japanese language and other skills in the sending country has only been six months in length and leading up to date of departure. However, for nursing care work, specialized Japanese language terminology is required. MHLW guidelines for the operation of the technical internship system for nursing care occupations stipulate that the first-year migrant employees with the requisite “specified skills no. 1” visa status must have passed the “N4” level in the Japanese Language Proficiency Test (JLPT) or an equivalent qualification.¹⁸ For this reason, trainees in the nursing care field receive instruction for one year, therefore requiring substantial commitment. This ultimately means that those wanting to work in this field in Japan spend more time and money prior to leaving their home countries than do their counterparts in other fields.

At present, eighty-two industries, including construction and manufacturing, are accepting technical intern, and many companies hire to cope with labor shortages or to suppress wages. As a result of this situation, numerous labor-related human rights violations have figured prominently in the national news. In 2019, the Ministry of Justice (MoJ 2019) reported that 8,796 trainees had been confirmed as “disappeared,” 1.7 times higher than in 2016 (5,068) (See MoJ 2019). This fact points to ongoing exploitation in various industries. However, this is not the case for trainees in the nursing care field, who are accepted by social welfare corporations. Most are young women in their 20s, and there have been few reports of “disappearances” nationwide in part due to some local governments’ active promotion of acceptance through subsidies.

In December 2018, the Japanese Immigration Control Act was revised to establish new visa residence statuses (*tokutei gino* [“specified skill worker”]) classified under specified skills for fourteen fields, including nursing care. In addition to passing JLPT N4 or higher in the sending country, those in the field of nursing care are required to pass the Japanese evaluation test for nursing care (Kaigo Nihongo Hyoka Shiken). The pre-pandemic expectation was to receive 60,000 workers in the nursing care sector over a five-year period starting from 2019 within 300,000 positions across fourteen industries. This plan was to serve as a receiving framework for those who would come to Japan under the EPAs and, importantly, allow in even those who would fail to pass the national examination for care workers within the stipulated number of years—a maximum of five—where their status of residence would still be “specified activity.” In other words, the Japanese government opened up an alternative way for those who failed the exam to continue to work in Japan. It allowed those who obtained more than half the required marks on the exam to come into the country and obtain a “specified activity” residence status. This overhaul of the visa system was to operate as a compromise designed to tap potential labor markets in an evolving care chain nexus so as to plug chronic care labor shortages.

The impact of the coronavirus and the government’s subsequent stringent restrictions on entry has meant that the number of people coming to Japan under the specified skilled worker system has been extremely limited due to delays in negotiations with sending Asian governments. The Immigrant Services Agency of Japan (ISA) has stated that the number of foreign nationals staying in Japan under the visa status of “technical intern”¹⁹ was 410,972 as of the end of March 2020 (ISA 2020; OIC 2020). In the same year, the number of approved technical trainee plans was 256,408, of which 12,068 were in the nursing care field. This accounts for 4.7 percent of the total (JITCO 2021).

In 2016, the Japanese government revised its Immigration Control Act to create a “nursing care” residence status (effective as of 2017). This was established as a partial response to the problem of foreign nationals graduating from Japanese schools and obtaining qualifications as care workers, but not being able to work as care workers in Japan. However, the reality is that, with many cases, “nursing care” residence status was being granted to international students who had entered or graduated from welfare vocational schools (*fukushi kei senmon gakkō*) or junior colleges via Japanese language schools and who had obtained the qualifications to become care workers. Of interest is the fact that those who came to Japan under the EPAs and obtained the qualifications of a care worker could now change their residence status from “specified activities” to “nursing care.”

With the establishment of the “nursing care” visa status, welfare colleges, which have experienced a large shortage due to a decrease in the number of students, have begun to focus on attracting foreign students. For local nursing care facilities, foreign human resources who graduate from vocational schools and obtain qualifications as nursing care workers are seen as a more stable and long-term workforce than EPA

Table 5. Number of Students Enrolled in Training Facilities for Care Workers and International Students (2016 to 2020)

Year		2016	2017	2018	2019	2020
Number of Maintenance Facilities (Courses)		401	396	386	375	347
Students enrolled		16,704	15,891	15,506	14,387	13,619
No. of Entrants		7,752	7,258	6,856	6,982	7,042
	New Graduates	6,060	5,360	4,847	4,180	3,936
	No of Job Leavers accepted for training	1,435	1,307	867	765	711
	No of int. students (persons by country)	257 (14)	591 (16)	1,142 (20)	2,037 (26)	2,395 (20)

Source: Japanese Association of Training Facilities for Carework (JATFCW)

candidates, many of whom do pass the stringent national examination. In many cases, they work part-time (no more than the twenty-eight hours per week as permitted by law) while attending vocational schools.

Over the past few years, the number of such (nursing) care students has dramatically increased across Japan. The Japan Association of Training Facilities for Care Workers (JATFCW) has shown that the number of foreign students enrolled in training facilities nationwide was only 257 in 2016 (Table 5). However, this has since rapidly increased over the years, rising to 2,037 in 2019. At the outbreak of the coronavirus, a total of 2,395 foreigners from twenty countries were enrolled in 2020. This accounts for 34 percent of the total number of students (7,042) enrolled in training facilities nationwide (JATFCW 2021). Thus, pre-pandemic the situation showed an evolving system diversifying and pulling in migrants to work in the care sector. Due to the high number of layoffs in the retail industry during the pandemic, some evidence points to students shifting to care work in the short term to cover income losses. This suggests a reorganization of labor to cope with the urgent need to provide societal care.

Refocusing Administrative Support and the Governance of Migrant Labor

As argued above, there has been an acceleration in the acceptance of technical interns and foreign students in the nursing care sector, which is especially pronounced in urban areas where there has been a chronic shortage of labor. Because of this trend, many nursing care facilities have accepted foreign workers. Here, we focus on Fukuoka Prefecture on the southern island of Kyushu. With a population of 5.1 million, just over 1.4 million are over 65 years of age (27.5 percent). In line with the national trend for aging, the prefecture suffers from a shortage of labor for the nursing care industry

(ratio +3.4). Over the last ten years, various individual, city, and prefecture initiatives have aimed at ameliorating labor shortages, including the provision of care giver training to resident migrants (Lopez 2012). This section focuses on Fukuoka's experience of assessing the labor situation under the pandemic through research conducted in late October 2020. Fukuoka was chosen as one location for research due to the existence of contacts from previous research projects in the region and due to low infection rates at the time of research.²⁰

To come up with strategies for caring for an aging population, the local government city hall has established an office for securing human resources for nursing care under the division responsible for the promotion of comprehensive care for the elderly. One basic principle adopted was to aim for the creation of a local society where the elderly play an active role in their communities as part of an ongoing elderly health and welfare plan.²¹ Internal figures collected show that the number of nursing care workers in the prefecture stood at 70,253 in 2013. By 2018, this had increased to 82,635 as the population aged. By 2025, it is forecast that 95,246 nursing care workers will be in demand. In line with the government's policy, the prefecture's policy for securing nursing care workers by 2025 is based on improving and strengthening measures to secure human resources domestically. However, this also includes securing foreign human resources considering the decline in the prefecture's working-age population and inability to entice local workers into the care industry. By 2025, Fukuoka City expects to suffer from a demand-side gap for care workers of around 5,500, and in response to this it preemptorily established a platform for accepting foreign nursing care workers in 2019. In 2021, the city aims to send several trained care workers to Myanmar to assist and provide guidance to those who wish to work in Japan and specifically to promote Fukuoka as an ideal region in which to work.²²

The prefecture is among a number in Japan that have a history of accepting nurses and care workers, and several care facilities have accepted them under the framework of the EPAs. Since then, 112 individuals have come to work in the prefecture (eighteen have obtained qualifications as nursing care workers). Forty-nine are from Indonesia (including five who completed their term, four who have passed the national licensing exam, and two who returned), fifty-seven are from the Philippines (including sixteen who completed the term, thirteen who passed, and three who returned), and six from Vietnam (one who passed the exam and one who returned). As of October 2020, twenty-two facilities in the prefecture had accepted eighty-four candidates for care worker positions. Most of these are in the southern part of the prefecture (Chikugo area), which has the largest shortage of workers. Running parallel to this are other local ventures that have trained foreign residents married to Japanese and with resident visas. One local company has trained over 300 (mainly Filipino women) between 2006 and the present.

With the acceptance of foreign nursing care workers, Fukuoka Prefecture has followed a similar national trend where technical trainees have far exceeded the number of EPA nursing care workers. Since 2019, there has been a significant increase at

facilities within Fukuoka City, and the data shows that the number of people the prefecture aimed to accept under plans approved by the OTIT by the end of June 2020 amounted to 439. The majority had already been deployed and been working at nursing homes in the prefecture. In line with the national trend and in terms of nationality, the most numerous care worker groups come from Vietnam (182), Burma (86), and Indonesia (42).

An interview with a prefectural official shed light on their engagements and revealed that Vietnam has one of the most developed systems facilitating the dispatch and acceptance of workers. Presently, Vietnam's government has an active policy of sending workers overseas, and the prefecture has taken advantage of this policy. Additionally, there has been a rapid increase in Burmese coming to Japan in the past few years, which Fukuoka has also accepted. In 2016, the city entered a sister city partnership with Yangon, which included sending a delegation to Vietnam, including the prefectural governor. Relations focused on cultivating "welfare missions" fostering ties to bring over trainee workers and foreign students. One plan prior to the pandemic was to send Japanese nursing staff to Yangon to train local nurses directly and raise the profile of the city (in part because foreign staff would often move to other larger cities where pay is higher and where there are more activities available to them). The city official had this to say:

From now on, we hope to be able to send a nurse to train (them) there directly . . . so it's our hope to send trainers to support education there as well as bolster education here and leave a positive impression of Fukuoka because many people inevitably go to Tokyo. Our recognition (as a city) is low.

However, through these newly forming networks, discourses on the kinds of qualities that migrant workers possess in respect to types of work are taking shape. The majority of Burmese are Buddhists, and there exists a widespread belief among more elder Japanese that caring for physically disabled elderly is a way of fulfilling the Buddhist doctrine of "accumulating virtue" (*toku wo tsumu*). As such, caring for the elderly is not a profession that is shunned; rather, it rests upon a particular worldview of religious relations. This view has spread to the nursing care industry and was also shared by the city official, who spoke of the Burmese migrants' "suitability" for such care work.²³ In an interview with the director of another care facility, a similar observation arose when the latter asked about whether the Burmese care workers, he had employed were suited to care work:

There might be personal differences, but on the whole their national qualities are close to ours. They are Buddhists and believe in accumulating merit and virtue for the next life and as such work hard.

With this new link in Japan's migrant care chain there is the risk in creating a new discourse that essentializes the national qualities of a people, which can serve to legitimize

the kinds of work they engage in. Discourses in the mid-2000s also framed an earlier stream of Filipino migrants as apt care workers based on their perceived national hospitality skills (Ito et al. 2008; Lopez 2012). The “accumulation of virtue” discourse is now employed by some companies to place emphasis on the merits of the trainees they bring over as “good” nurses who will bring a valuable service that does not culturally destabilize Japanese practices. This fits into a capitalist discourse about matching (creating) a suitable labor pool to a particular market to fill with workers.

Aside from the above initiatives, another reconfiguration is taking place. In the prefecture, there are fifteen vocational schools and other institutions for training care workers. Some 277 (49.6 percent) of the total 559 current students are international students. The students are mainly concentrated in Fukuoka City, where 142 international students are studying.²⁴ At the prefectural level in this field, foreign students numbered 67 in 2018. As such, this means that the number has quadrupled since then. Foreign students are able to switch their residence status to “nursing care” once they graduate and obtain a nursing care worker visa.

At one prominent medical and welfare college (vocational school), interviews with foreign students training to be care workers (Chinese, Burmese, and Vietnamese) and the chief in charge of education there revealed that the pandemic had led to a new stream of students shifting over to studying care due to the collapse of work in the food, retail, and hotel industries, where many students would work part time. The chief said:

We had a request from one company with strong contacts with Vietnamese foreign students (in Japan), who were aiming to work in [the] advertising, food and hotel industries, that they would like to shift to the care sector. Some students had been studying hospitality at technical colleges and are now switching to care. The pandemic really brought the winds of change (to Japan).

The impact of the pandemic has reoriented the flow of student labor (as a potential buffer workforce in Japan). As a result of this trend, the college provides (sells) a package of training to facilities that will become guarantors for the students. They will pay for their daily expenses and once they graduate, the students will work full time for these facilities. Students who graduate and work night shifts are guaranteed an initial monthly salary of JPY190,000 (USD1,738) after tax. The students who strategically come to train and then work and settle in Japan have been termed “migrant working students” (*dekasegi ryugakusei*), a new phenomenon arising from the need to increase temporary labor in the workforce.²⁵ The director of one college offering packages to students to study care frustratingly noted how difficult the situation was in responding to Japan’s urgent needs for care labor:

If we don’t match workers to fields such medical education through a labor policy, they won’t stick around. Japan’s migration strategy is a halfway measure, and if we don’t take a more friendly stance toward foreigners, no field will be able to survive.

A temporary internal reconfiguration is taking place to deal with the demand of care workers in a vastly undersupplied market through recruiting students. It is being somewhat stymied by political aversion to developing a more concrete migration policy. In a way, Fukuoka's experience offers a microcosm of the issues that many other prefectures are presently facing in the country under the pandemic.

Transformations in Hiring Trends in Nursing Care Facilities

At present, in Fukuoka Prefecture, technical interns and nursing care students are the main group of hired workers and not EPA care workers. One president of a local care training company,²⁶ Nakamura Masahiro, has been at the forefront of an independent initiative to retrain foreign migrants, which has been providing employment support and training for foreigners since 2006. In an interview, he made it clear that "in Fukuoka and other parts of Kyushu, EPA personnel do not stay for long, so businesses are switching their employment to technical interns." One social welfare corporation in the Chikugo area had been continuously accepting EPA Filipino candidates for care workers since 2009. Yet from 2020, the focus has shifted to hiring technical interns from Myanmar. In part, this is due to a low retention rate, as many nurses move to larger urban areas where wages are higher. So far, nine people have passed the national exam, but only three of them have continued to work as of October 2020. After obtaining national qualifications, foreign nationals working under the EPAs can freely transfer jobs without restrictions. This has meant that the outflow of human resources to urban areas has become a source of concern for local care provider organizations, which have repeatedly experienced this trend. However, this trend was not exacerbated under the pandemic.

Foreign students in the nursing care field are granted a provisional national license as a nursing care worker if they graduate from a training facility. This they obtain on passing the national examination within five years of graduation or if they gain five years of continuous practical experience in nursing care. Facilities offer scholarships under a contract where students will work for a certain period after graduation, and there is an expectation that this will be a more stable workforce than EPA personnel. Recent research on facilities operating long-term care services has shown that a substantial number of foreign students and technical interns have become a dominant stream of labor exceeding care workers who arrive due to the EPA program (NCLSC 2020). This suggests that prior to the pandemic one part of the emergent care nexus was diversifying in order to capture different labor streams in a flexible fashion. The pandemic accelerated the speed at which these streams were reorienting to deal with the need to fill vacancies in the care market. Within this context, we now turn to discuss what problems staff care residences faced under the coronavirus pandemic.

The Challenges of Care during the Pandemic: Impact on Care Workers in Facilities

Over the course of the ongoing pandemic, nursing care facilities have had to deal with the fact that elderly people have a high chance of becoming seriously ill due to infections from the coronavirus. Elderly welfare facilities have been the worst, with 1,498 registered infections (up to 17 May 2021). At these facilities, foreign staff, as well as their Japanese counterparts, have been forced to work and live under a great deal of stress. In late October 2020, ten nursing care technical interns from Vietnam and Myanmar, and five Chinese and other international students from a welfare college were interviewed about their motivations for coming to Japan, their current circumstances, and life under the pandemic. Many shared a primary concern over restrictions on personal activities. One Burmese technical intern (mid-20s), who had entered Japan in March 2020 days before entry restrictions, spoke of the monotony of going back and forth between her workplace at a special nursing home for the elderly and her apartment. Her employer had instructed her to only go out to shop for necessities, and she could rarely walk around the vicinity of her apartment.

Among the interns, one Vietnamese woman (mid-20s) became a trainee in the field of nursing care shortly after completing five years as an intern in the field of agriculture. This was possible due to a special government measure that allowed trainees who were unable to return to their home countries due to the pandemic to work in other occupations that they previously they had not been allowed to before. Due to an unstable income during harvest seasons, this woman's monthly take-home pay was more than JPY100,000 (USD917), but during the off-season this was reduced by half. A high level of proficiency (N3) worked to her advantage when she sought out a job in the field of nursing care, which she is currently training in. When asked about why she chose to go to nursing, she replied that it "because it is what I want to do in the future. This is so that my Vietnamese grandparents will be as happy as the Japanese in the future." The number of Vietnamese and Burmese technical intern trainees working in the field of care has risen significantly over the last year, yet many came to Japan with numerous motives. In one group interview with four Vietnamese care work interns (arrived in January 2020) at an intensive, day-long care training session, two trainees with N4-level Japanese explained that they were previously nurses (one an anesthetist, another a general nurse) at two general hospitals in Hanoi before deciding to come to work in Japan, partially out of interest in Japanese popular culture and partially to gain new skills in another language.

One thing that stood out for them is the existence of care homes for the elderly due to the lack of private nursing homes within Vietnam. As a culture with strong collectivist tendencies where the elderly are treated with deference and respect and live with children or grandchildren, coming to work in Japan in day care and long-term facilities came across as a shock:

In Vietnam, day care services for the elderly don't really exist. If something happens you just go to the hospital. We don't do care work for the elderly. So, when I first came here to do this, I was quite shocked. It was quite a surprise for us.

However, jumping into care work during a pandemic did not pose a great challenge for them as trained nurses, and they did not experience any major problems in their workplaces. Aside from restrictions on travel outside of work, they followed masking and disinfection procedures, something they had experience with from their work in Vietnam. Despite language difficulties, particularly with the local dialect the elderly use, they related that the professional training they received in Vietnam and subsequently in Japan translated into a positive experience to help them cope as they adjusted to new working conditions.

A different picture emerged at two care facilities that employ nursing care workers from several countries under four different streams: EPA nursing carers, those who graduate from local junior colleges with recognized qualifications, technical trainees, and foreign students. One facility (A) with a capacity for up to eighty elderly persons, had extensive experience in accepting workers and currently employs a mixture of EPA, foreign students, and technical interns to cover its deficits (from Myanmar, Vietnam, the Philippines, Sri Lanka, and Nepal). Early in the pandemic, the facility registered a mild outbreak of infection. The employer swiftly suspended Japanese nursing staff who had children or other family members living with them from going to work for up to two weeks. Yet foreign staff, who were all single, continued to work to cover the shortages, resulting in a substantial increased workload. Some of them had their night shifts doubled, which is usually only permitted a few times a month. As the facility manager put it, "they worked at full steam and were very active." One carer was Ms. A (mid-30s), a Filipino national who came to Japan under an EPA and obtained her qualification as a certified care worker in 2015. A unit care leader with fluent Japanese, she spoke of her experience in English mixed with Japanese:

I worked about ten night shifts a month, and sometimes I had to work until around 1 pm, after the night shift, when my work would usually end at 9 am. Even then, there were times when I couldn't provide high-quality care to the residents because the workplace was less crowded than usual. I'm supposed to help with bathing twice a week, but sometimes I had to do it once because we didn't have the manpower.

And, her relationship with her colleagues was also affected:

Some of us were stressed, some of us were a little upset, and there was some misunderstanding. Some Japanese resigned because of the stress of corona, and my EPA colleagues also felt stressed. Since we couldn't meet with them as before, we exchanged messages in a LINE group and shared with each other how stressed we were. I made them some Filipino food and gave it to them, which made them feel better. I thought about them (my colleagues), and we felt each other's feelings.

Furthermore, the practice and awareness of care for patients also changed in some ways:

At work, I always wear a mask and (plastic) gloves. And I'm more sensitive to my patients (the residents) than I used to be. I also avoid body contact, but sometimes I can't avoid it. I still hold my patients (which I used to do), but I don't hug them anymore.

She also spoke about her personal life under the ongoing pandemic:

We can't go out freely . . . *seigen sarete imasu* ("like we are restricted"). We have, for example, precautions . . . of course working here as a care worker and dealing with older people every day. . . . When I go to the supermarket or when I do my grocery shopping, I'm like "oh, I have the coronavirus and I shouldn't stay here for long," so I leave after ten or fifteen minutes. I've also stopped going to the Catholic church, which I used to go to every Sunday, because I'm afraid (of the infection). I can't go anywhere; it's so stressful.

Employers did not prohibit staff from going out into crowded urban areas. However, in wanting to counter the virus, facilities would quarantine residents with fever or those coughing, for certain periods of time, and ensure ventilation. Such tension in the workplace led to the narrowing of the living space for Ms. A and other foreign staff, and to self-restraint in everyday activities.

The facility director made clear some of the problems that foreign staff had to confront. Young Burmese trainees who had only been in Japan for a short time became mentally unstable under conditions and expressed a desire to return home. The employers responded to the situation by asking other colleagues to prepare food from their home countries and bring it to the workplace. In an interview, the Japanese director noted that there were times when friction arose in relations due to the increasing stress of life both physically and mentally, but as they were forced to deal with this crisis, solidarity between staff increased. Reflecting on the overtime and efforts they made throughout the pandemic, the director said:

Here in the workplace, they really worked hard, and we see them differently now. You really think about this. Friction arises (between Japanese and foreign staff) as we get tired, but this is the same for us Japanese.

What should be noted is that those who came under the EPA system demonstrated a high professional capacity to work as the pandemic played out. Many are graduates of nursing colleges in their home countries, and some of them, like Ms. A, are registered nurses in their own countries, whose training meets global standards. The facility director candidly remarked:

They (the nurses with qualifications from overseas) are more qualified than the technical interns and foreign students at responding to emergencies or when something is wrong with patients, and have a better understanding of clinical issues . . . They (the foreign staff) are warm. And in terms of respect for the elderly, they are better than [the] Japanese.

These interactions present a reevaluation of foreign workers in Japan's healthcare system as frontline personnel. Whereas previously the presence of migrant healthcare workers may have remained relegated to the fringes of discussions on solutions to labor shortages, this particular care home now aims to increase foreign staff to just under half of their total once the pandemic subsides. These micro-level encounters may shift opinions on the procurement of migrant labor when the pandemic abates and allow us to observe some of the possibilities of a post-COVID-19 Japanese society that becomes more flexible in attending to a demographic crisis that will not abate.

Responding as Managers for Foreign workers

Another important issue that is arising is the newly emerging trend of employing foreign staff as managers of foreign and Japanese staff in the workplace. These positions have gone to EPA nursing care workers with high-level Japanese and the capacity to manage staff both Japanese and foreign. Ms. B (mid-30s), a Filipino EPA certified care worker and manager at one healthcare facility in Fukuoka shared her experiences during the initial lockdown in April 2020. During an interview, she indicated that Japanese staff were more anxious and tense than their foreign counterparts:

They [Japanese care workers] said that the virus [corona] will never end, but I replied: "Any disease [viral infection] will come to an end, so don't worry."

However, she remained optimistic that the situation would improve, and shared a discussion she had had with a concerned fellow Filipina while comforting her. She related how she reassured her colleague: "You can always go home when it (the pandemic) settles down. In a follow-up interview in late October 2020, she noted that her life was the same as before and that she was avoiding the risk of infection by eating lunch in her car:

Some friends [Filipino colleagues] were lonely and lost motivation to work and study (for the national examinations and so on), but they seemed to calm down when I talked to them.

Asking about the difficulties of life during the pandemic, she answered that she was "not being able to go anywhere," a common point raised in other interviews as well. Since the beginning of October 2020, when infection rates decreased, her facility finally allowed family members visits to patients, but only by appointment and only for ten minutes in a designated space. Employers did not prohibit travel outside the city, but did request that people travel by car rather than by train. Even so, since March 2020 Ms. B has refrained from traveling to the city center, where there are many people, and shared her concerns about becoming infected: "I'd like to go, but I wouldn't be able to forgive myself if I'd brought it (the virus) back."

These examples of Filipino nationals considering the needs of others stem partially from the sociocultural care connections that form between them and others, and that are fostered in a different cultural context. However, it is also partially in reaction to and in interactions with Japanese norms regarding distancing (*kyorikan*) and thoughtfulness (*omoiyari*). The way that different care regimes interact presents the complexities of micro-encounters and the ways in which foreign and Japanese healthcare personnel may be party to negotiating and producing a newly emerging “socioemotional commons.” As some researchers have recently noted, this is a space where different intimate care regimes (embodied and discursive) merge and interact, transforming and producing new notions of care (Navallo 2020).

Over the past couple of years, the number of “care migrants” in Japan have dramatically increased, and this been accompanied by persons trained within different care regimes with varying levels of technical skills, language ability, and cultural understandings of care. Accepting nurses and care workers has been more a symbolic token gesture than a move that addresses core issues in Japanese society. To date, migrants have not been considered as part of any long-term solution to Japan’s demographic contraction.

However, the pandemic has starkly offered a very clear *encounter with difference* at an everyday level through both Japanese and migrant workers collectively caring for the nation’s elderly. Local government and the private sector, which were accepting foreign nationals, have had to restructure employment strategies in the direction of promoting the acceptance of foreign human resources and shift to student labor streams in the short term. Yet, labor shortages in the nursing care field will remain acute for the foreseeable future and those foreign staff who have been frontline “essential workers” have come to present a very different alternative for who can work and contribute to the societal safety and security of the nation.

Peter Herrmann and colleagues have noted that social quality theory aims to “discriminate among different types of daily life to inform social and other policies oriented on society” (2012: 96). Yet this requires that we keep in mind the complex interactions between those who provide care, those who receive care, and interaction between both the intimate and public domains. This is not just about improving the capacities of care for the elderly, but a deeper reflection on the body politic itself and how political communities interpret a broader transnational sense of well-being that leads to improved social quality. The examples in this article suggest that the effects of the pandemic may open up a more public discussion and change the direction of conversations over who can participate in the future constitution of Japan as long-term migrants raise questions about who can become citizens and care for Japan’s elderly.

Conclusion

In this article, we have argued that the disruptive force of the coronavirus pandemic may sow the seeds for a more humanistic approach to Japan's care dilemma once it abates. Foreign care workers have come to demonstrate clear nursing care knowledge and an ability to work through a pandemic on par with their Japanese counterparts. This has subsequently gained them recognition as senior staff and managers of Japanese and other foreign staff. And this has not gone unnoticed in the hotbeds of cultural interaction between new highly skilled migrants from Asia. The outflow of qualified foreign care workers to metropolitan areas will remain a dilemma for facilities in rural areas. And the situation in the early part of 2021 shows that the endgame to the pandemic has yet to play out in Japan.

However, "essential workers," domestic and foreign alike, will provide politicians, policymakers, and the public with a new discussion that must be held to consider the future role of who constitutes and who will care for an aging society. To publicly acknowledge this fragile dependency allows for a more accountable discussion in comparison with other nations that at a global level are competitively reorganizing their migration streams to provide care. Individuals who provide care, in effect, have raised the unavoidable question of the consequences of outsourcing a degree of societal care through tapping labor markets in the region.

This article suggests that a more detailed examination of care dynamics at a micro level will provide us with evidence for the need to create a more flexible pathway to understand what type of "socioemotional commons" is developing in Japan. At the heart of all societies rests an unconditional contract of providing care across our life cycles. However, the current care nexus dilemma in Japan will not improve without a reflective overhaul of what constitutes Japan itself. A part of the solution will ultimately rest in the body politic, which, as it ages, will place a conditioned demand for care that intimately ties Japan to the Asia-Pacific region and further beyond.

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Notes

1. In Japanese, *kangoshi kohosha* (“foreign nurse candidate”) and *kaigo fukushishi kohosha* (“care worker candidate”). On passing the national nursing exam or the national examination for care workers, nurses and care workers become certified, respectively.
2. Workers from these countries arrive as designated “candidates” due to the requirement of sitting and passing the Japanese Nurses National Board Examination.
3. This vision was put forward in a reported titled *The Japan Revitalization Strategy 2014* (Prime Minister’s Office of Japan 2014).
4. Act on Proper Technical Intern Training and Protection of Technical Intern Trainees No. 89, 2016. See <https://hourei.ndl.go.jp/#/> [in Japanese].
5. This was the first confirmed case in China from a man who traveled to the country. See NHK (2020).
6. As of 15 May 2020.
7. A guide to avoiding the 3Cs [in Japanese]: <https://www.kantei.go.jp/jp/content/000062771.pdf> (accessed 9 August 2021).
8. The emergency law enacted at the national and local levels is not legally enforceable; as such, the Japanese government had to resort to “appealing” (*yosei*) to people; they could not “demand” (*kyosei*) that the general public obey.
9. The declaration of the state of emergency for new coronavirus infections (a government decree in Japanese) was enacted through the Act on Special Measures against Pandemic Influenza (Act No. 31, 2012). See https://corona.go.jp/news/pdf/kinkyujitai_sengen_0407.pdf (accessed 15 June 2021).
10. Returnees were required to undergo quarantine, and to test negative for COVID-19.

11. A green, yellow, and red color system is employed to help the public visualize the situation. A dedicated Japanese language site with information in thirteen languages is currently in use: http://www.pref.osaka.lg.jp/iryo/osakakansensho/corona_model.html (accessed, 1 December 2021).
12. The four stages all relate to the healthcare delivery system: (I) no sporadic outbreaks of infected persons and no particular disruptions; (II) gradual increase in the number of infected persons; (III) measures needed to avoid rapid increase in the number of infected and major disruptions; and (IV) action required to avoid the explosive spread of infection. See https://corona.go.jp/news/pdf/jimurenaku_0811.pdf (accessed 25 November 2021).
13. At the beginning of the 2020 fiscal year, a substantial portion of the national budget was set aside for this scheme. The national taskforce for dealing with the coronavirus halted the campaign partially due to its epidemiological impact, an association of higher infections, and their spread through persons traveling around the country. Subsequent research has confirmed that the campaign was associated with a higher probability of exhibiting COVID-19 infection symptoms (Ansai and Hiroshi 2021; Miyawaki et al. 2021).
14. Information on the status of healthcare and the number of hospital beds for hospitalized patients can be found at the MHLW site <https://www.mhlw.go.jp/content/10900000/000824884.pdf>, which reports data as of 25 August 2021 (accessed 25 August 2021).
15. The focus of this research was care workers. Nurses under the EPA framework were also interviewed but not included in the interview sample for this article.
16. Face-to-face interviews and online interviews were recorded with permission from the participants. These were transcribed and categorized to identify societal impacts.
17. Information based on press releases from the Japanese Ministry of Foreign Affairs (MoFA). See Entry of the 7th batch of Vietnamese nurse and care worker candidates under the Japan-Vietnam Economic Partnership Agreement (JVEPA), 9 November, 2020; entry of the 13th batch of Indonesian nurse and care worker candidates under the Japan-Indonesia Economic Partnership Agreement (EPA), 16 December, 2020. (MOFA 2020a, 2020b); and EPA News. Schedule for Filipino Care Worker and Nurse Candidates entry to Japan (JICWELS 2021).
18. The JLPT has five levels N1 through N5. N1 is the highest level and N4 equates to possessing the ability to read and understand basic Japanese vocabulary and Chinese characters as well as having the ability to understand basic daily conversation.
19. Two types of internship visas exist, No. 1 and No. 2. The major difference between these is that the first only allows a nonrenewable stay of up to five years and does not permit the migrant to bring their family with them. The second is for those with more advanced skills, and allows them to be accompanied by family members.
20. It has also been the focus of detailed studies scrutinizing how the rapid rise of migrant labor is transforming local society (Nishi Nihon Press 2020).
21. This is in line with the national policy of supporting the independence of the elderly and goes beyond the provisioning of long-term care.
22. Information based on an interview at the Department of Human Resources for Long-term Care, Elderly Affairs Policy Section of Fukuoka City, 28 October 2020. Considering the current political situation and impact of the coronavirus, this information may have changed.
23. This view is also shared by another major recruitment company that has a training school in Yangon. This view in the nursing care industry may be linked to the rapid increase in the number of Burmese nursing care workers. The above view was also expressed by other Japanese care facility managers who employ Burmese care workers.
24. By nationality, there are 107 students from Nepal, 53 from Vietnam, 51 from China, 34 from Myanmar, 12 from the Philippines, 8 from Sri Lanka, 5 from Bangladesh, 3 from Indonesia, 2 from South Korea, and 1 each from Taiwan and Mongolia.
25. The Japanese language daily newspaper *Nishi Nihon* coined this term in a detailed volume focusing on the rise of students making up for deficits in the local labor force. See Nishi Nihon Press (2020).
26. This company has been recruiting and training local foreign residents, mainly Filipinos, since 2009, and is based in Ogori City, Fukuoka Prefecture.

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