Gender and Ethnicity in Japan's Health-Care Labor Market

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Summary
As the socialization, privatization, and internationalization of health-caregiving proceeds, in many industrialized nations the health-care business, which was often a gendered labor market to begin with, is now evolving as a labor market at the intersection of gender and ethnicity. This paper addresses a bipolar concept of invisibility—and potential vulnerability—of female labor migrants through the lens of gender and ethnicity in the health-care labor market in Japan. It does so by introducing the roles both dimensions play in Japan's labor market in general and in the health-care sector in particular. Juxtaposing two different groups, namely longtime foreign residents of Japan entering the health-care business as a second career option on the one hand and newly arrived health-caregivers from Southeast Asia on the other hand, the paper first highlights the commonalities and differences in the way gender and ethnicity impact the structures of life and work in Japan for the two groups. Secondly, the paper looks at the interlocking dimension of gender and ethnicity and provides some insights into the intersectionality of these factors in Japan's labor world.

Keywords: Japan, labor market, health care, migration, gender, ethnicity, intersectionality

1. Introduction

Japan's population is aging at unprecedented speed. How the nation is coping with the manifold challenges that this development poses to an already strained economy, to politics in a state of seemingly endless turmoil, and to a society that is looking out for new values and norms to provide it with stability in a transformed globalized world has already been the subject of countless academic and non-academic publications.[1] There is one aspect of the impact of demographic change that is particularly affected by the three main demographic variables of population aging (mortality), population reproduction (fertility), and population mobility (migration), namely health care for the elderly. The more a population ages, the higher the share

[1] For a comprehensive account on the many impacts of Japan's demographic change, see Coulmas, Conrad, Schad-Seifert and Vogt (2008), for example. Also note the special report in *The Economist* (2010/11/18).

of those potentially in need of elderly health care and the lower the share of the working-age population and those who can potentially provide health care to the elderly members of society. Moreover, in many industrialized nations, elderly health care becomes an increasingly pressing issue not only because of the sheer rise in the population's median age, but also due to a shift of reproductive work such as elderly health care from within the families into the realm of public institutions and private markets consciously chosen by family members.

With the demand for health-caregivers catering to the needs of the elderly rising rapidly at a time when the pool of caregivers is shrinking, migration—and in particular international labor migration—comes into the picture as a potential solution to this crisis. In fact, population aging in many industrialized nations has provided a strong, new "pull factor" in international migration flows,[2] and the international migration of health-caregivers has long become big business on a global scale (Kingma 2006; Piper 2005: 35–36). As the socialization, privatization, and internationalization of health-caregiving proceeds, in many industrialized nations the health-care business, which was often a gendered labor market to begin with, is now evolving as a labor market at the intersection of gender and ethnicity.[3]

This paper addresses a bipolar concept of invisibility (Brettell 2000: 111)—and potential vulnerability—of female labor migrants through the lens of gender and ethnicity in the health-care labor market in Japan. It does so by introducing the roles both dimensions play in Japan's labor market in general and in the health-care sector in particular. Juxtaposing two different groups, namely longtime foreign residents of Japan entering the health-care business as a second career option on the one hand and newly arrived health-caregivers from Southeast Asia on the other, the paper first highlights the commonalities and differences in the way that gender and ethnicity impact the structures of life and work in Japan for the two groups. Secondly, the paper looks at the interlocking dimension of gender and ethnicity and provides some insights into the intersectionality of these factors in Japan's labor world.

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2 Studies based on independent variables such as demand-pull and supply-push stress the economic dimension of international migration (Hollifield 2000: 141–142).

3 Generally, "class" needs to be added to these intersecting categories as yet another dimension within the health-care labor market, since low pay and low status characterize the nursing profession worldwide and international migration in the health-care sector often goes hand in hand with a social downward mobility, thus increasing the economic vulnerability of labor migrants. Social anthropologist Caroline Brettell (2000: 111) calls class, ethnicity, and gender the central factors constituting the "triple invisibility" of female labor migrants. Compared to ethnicity and gender, however, in Japan, class is much weaker as a determining factor for female migrants entering the health-care labor market. Female labor migrants in the health-care sector are protected by the same labor standard laws as Japanese health-caregivers, and since the newly emerged migration avenue, which is the focus of this paper, is accessible to institutionalized care structures only, Japan rarely sees the phenomenon of an exploitation of live-in caregivers so prevalent in other aging nations. See, for example, Bommes and Sciortino (2012) on case studies about irregular migration into the European nations' welfare labor markets.

2. Research Design

One approach by which to address these invisibilities through gender and ethnicity and their interdependencies in the Japanese health-care labor market is the concept of intersectionality, which is drawn from sociological research on the growing gaps in modern societies.[4] The influence of different and, indeed, differentiating categories, such as gender and ethnicity, which manifest themselves in various phenomena and processes and intersect with each other, can be studied empirically as well as on a purely conceptual level.

Two representatives of contemporary gender studies, Nina Degele and Gabriele Winker, suggest highlighting not only the intersection of categories of difference, but also taking into account three levels of analysis, namely social structures and institutions (the macro level), identity formation (micro level), and cultural symbols (level of representation). This approach illustrates that the relevance of various categories of difference not only depends on the research subject itself, but also on the level of analysis a researcher chooses. Moreover, the research findings on each level influence those on the other levels. Degele and Winker (2007: 1–3, 15; Winker and Degele 2009) argue that the shaping of identities on the micro level is therefore deeply connected to patterns of discourse and structural patterns, and vice versa.

While the authors of this paper acknowledge the importance of a multi-level approach in intersectionality studies, the paper at hand will limit itself to studying the macro level, in particular the institutions, and to some degree the social structures as represented in ideologies, for example, thereby hinting at the level of representation to a certain extent.[5] We understand both institutions and ideologies as determining factors that shape and reinforce the division of Japan's health-care labor market along the categories of gender and ethnicity.

We consequently support the understanding of sociologists Arianne Gaetano and Brenda Yeoh (2010: 6) that further research was desirable on the mechanisms of

> how migrant women's economic contributions are obscured or undervalued by deconstructing the gendered dichotomies of public/private and production/reproduction and exposing the ideologies and institutions that construct them.

The health-care sector serves as a primary example for studying the very institutions and ideologies that construct the gendered dichotomies of the public and private realm and the areas of productive and reproductive work. All the more so in Japan, a country that only recently opened its domestic labor market to health-care migrants

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4 For further reading on intersectionality see Lutz, Herrera Vivar and Supik (2010), Klinger and Knapp (2005), Klinger, Knapp and Sauer (2007), Degele and Winker (2007), and Winker and Degele (2009), for example.

5 By focusing on the institutional level, this paper takes a different approach from several established studies on intersecting categories, which highlight the micro level of identity formation (Klinger and Knapp 2005).

and is currently (re-)negotiating the institutions and ideologies prevalent on the ground (*gemba*), that is where actual health-caregiving takes place, as well as in the policy field and its associated discourses.

After providing a basic outline of the dynamic changes in Japan's health-care sector and their roots in section three of the paper, we shall present the roles of gender (section four) and ethnicity (section five) in Japan's labor market and the health-care sector in particular. The leading question in these sections is whether the structural shifts following an increasing socialization of the reproductive work of health care open up policy opportunities for the formation of a gender-neutral sector in the Japanese labor market, or whether we will in fact witness the reinforcement of gendered structures in this particular sector as an outcome of this process. On the basis of our qualitative content analysis of government documents and writings prevalent in the public discourse, we will argue that the latter is the more likely process. We will present our preliminary research outcome in terms of the intersectionality of the categories of gender and ethnicity in Japan's health-care labor market in section six.

3. Japan's Health-Care Sector

In Japan, the socialization, privatization, and internationalization of health-caregiving is currently underway. As the reproductive labor of health care gradually shifts from the private realm of the family to the public realm of non-profit organizations and businesses, the demand for labor in the sector of health-caregiving is growing. This increased demand is brought about through socialization and privatization of health care and is partially being met by the preliminary internationalization of health care. Three changes within this dynamic deserve a closer look in particular. These are the numerical change in the demand for elderly health care, the accompanying value change among potential givers and receivers of health care, and structural changes in health care for the elderly.

The numerical change in the demand for elderly health care is reflected in Japan's demographic change in general and in population aging in particular. The old-age ratio of people aged 65 and over is predicted to quickly rise from 20.2 percent in 2005 to 30.5 percent by 2025 and 40.5 percent by 2050. With the risk of becoming dependent on health-care services sharply rising with age (from 3.8 percent for a 65-year-old to 24.1 percent for a 75-year-old), and the age group of over 75-year-olds in Japan expanding in particular,[6] the Ministry of Health, Labour and Welfare (MHLW) predicted that the number of people claiming assistance in health care through the system of "Long-term Care Insurance" (LTCI, *kaigo hoken*) was going

[6] While the population segment aged 75 years and older stood at 9.1 percent in 2005, it is predicted to rise to 18.2 percent by 2025 and to 24.9 percent by 2050 (NIPSSR 2008: 15–16).

to rise from 4.5 million in 2007 to 8.4 million by 2025 (MHLW 2007; NIPSSR 2008: 15–16).[7]

Besides this numerical increase in the potential demand for elderly health care, Japan is also experiencing a value change that goes hand in hand with a structural change, both of which accelerate each other and symbolize the ongoing processes of socialization and privatization of health care. While 57.3 percent of elderly Japanese agreed with the statement that "[i]t is just natural when children provide care to their own parents" in 1995, this figure fell to 48.6 percent in 2003. Also, the ratio of persons in the caregiving generation who agreed with the notion that "[j]ust because I am their child does not mean I need to provide care for my parents" rose from 28.7 percent in 1995 to 36.1 percent in 2003 (CAO 2004). This longitudinal survey commissioned by the Cabinet Office in Japan (CAO, *Naikakufu*) gives us some valuable insights into the change in attitude that has occurred regarding the necessity of providing health care to the elderly both among the care-receiving and the caregiving generations.

The acceptance of health care as a task to be provided not only within the family but also by public and private institutions has been rising significantly, and newspaper opinion polls have regularly shown that seventy to eighty percent of the Japanese population is in favor of an advancement of the "socialization of care" (*kaigo no shakaika*) (Campbell 2008: 661).[8] The period covered by the CAO's survey outlined above is particularly interesting, as it spans the time before and after the introduction of the LTCI system in the year 2000.[9] LTCI made financial assistance in health care available to the general public over the age of 40 for the first time. It did so in a highly comprehensive manner, which led political scientist John Campbell (2008: 661) to characterize the system as follows:

> The scope and generosity of Kaigo Hoken gives Japan one of the most highly developed long-term care systems in the world—for example, more than double the size of the German program, the other major example in the social insurance approach. This is the first time that any aspect of the Japanese welfare state has been out in front of the world.

Today, local public institutions (*chihō kōkyō dantai*), private companies (*eiri hōjin*), cooperative associations (*seikatsu kyōdō kumiai*), and non-profit organizations

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7 Economist Naohiro Yashiro says it is "obvious that the potential demand for health-care services should increase with increasing numbers of the elderly," given that "[t]he average expenditures on health-care services of those aged 70 and above are about three times those of the health insurance schemes" (2008: 33).

8 Despite this general trend toward the socialization and privatization of health care, the family still plays a central role in health-caregiving for the frail elderly (Roberts 2011: 572); see also section 4.2.

9 For more details on LTCI, see, for example, Campbell (2000 and 2008), Ikegami and Campbell (2002), or Shimada and Tagsold (2006), and for background information on the development of social policies in Japan regarding the elderly, see Maeda (2000), for example.

(*NPO-hōjin*) are among the institutions providing health-care services outside the family (MHLW 2006: 2). The lion's share of the costs of health-caregiving is met by the local government; the patient's private burden amounts to a mere ten percent of the sum, with patients on social assistance being exempted from this contribution. Recent data show that the provision of home-based health care has increased dramatically, rising to 2,510,000 cases from 2000 to 2005—an increase of 159 percent (MHLW 2006: 2). A growing number of elderly people are, indeed, coming to rely on the various health-care options provided by care workers from outside the family.

Contrasting this increase in the demand for elderly health care is a lack of service providers on the supply side. While the number of professional staff involved in elderly health care has increased quite notably (it actually tripled between 1996 and 2005, rising from 13,181 to 35,494 employees), the proportion of nurses per 1,000 persons still stands at the very low level of 6.4 nurses per 1,000 people—compared to 10.6 in Sweden, 9.9 in Canada, and 9.7 in Germany, for example. With regard to the ratio of beds in health-care facilities, on the other hand, Japan has the highest ratio in an international comparison: 12.8 beds per 1,000 people in Japan, as opposed to 2.2 in Sweden, 2.9 in Canada, and 6.4 in Germany (JNA 2006). The story told here is one of staff shortages, the most pressing problem in providing adequate health care to the rising number of elderly Japanese opting for health care outside the family.

While Japan's demographic change gives reason for the urgent need to compensate the labor shortage in the health-care business, the changing attitude toward institutional health care prevalent in Japanese society and the introduction of LTCI laid the grounds for changes within the ideological and institutional frameworks in Japan's health-care sector. Before discussing the impact of international labor migration to Japan in this sector, we shall now turn to labor-related aspects of institutional health care seen through the lens of gender studies.

4. Gender in Japan's Health-Care Labor Market

In this section, we shall first focus on the gendered dimension of the Japanese labor market in general and then go on to discuss some of these aspects in relation to gender within the health-care labor market. Our principal intentions are, first, to evaluate institutional and ideological changes regarding the participation of women in the labor force and to expose the limits of these changes by highlighting existing constraints on gender equality in the current Japanese labor market. Second, we shall examine the effects of the ongoing socialization of care for employment structures in the health-care labor market. As we shall see, this structural shift does not necessarily include a shift toward more gender equality within the highly gendered sector of reproductive care work.

4.1 Gender and Japan's Labor Market

Throughout the 20th century, the Japanese labor market continued to have a highly gendered structure, which to a certain extent persists to this day.[10] Yet the labor market also saw significant institutional and ideological changes that could be best described as a turn from "housewifisation" (Hara and Seiyama 2005, quoted in Suzuki 2007: 8) toward the "feminization of employment" (Suzuki 2007: 8). This means a shift from the classic breadwinner model that grew common during the era of enormous economic growth during the 1960s to rising numbers of female employees in the labor force today—from 17.3 percent in 1955 to 40.5 percent in 2009 (GEB 2011)—and changing patterns of age, marital status and educational background among the female workforce. Today, women continue to work after getting married; they are an integral part of the workforce, not only at a very young age but at a higher age as well, and they are often well educated (Ōmori 1993: 85–86).

However, despite the rising number of working women and ever more opportunities for women to attain better career positions, we also have to realize that the Japanese labor market still remains highly gendered. In an international comparison, the quantity and quality of female participation in the Japanese workforce are rather low (Suzuki 2007: 13). Also, the wage gap between men and women "is known to be the largest among OECD countries" (Kawaguchi 2009: 2). Of all the working women in Japan, 67.7 percent had an annual average wage of less than 3,000,000 Yen in 2009.[11] Compare this to men: only 25.1 percent had to make a living on such a low average wage (COGEB 2011). One argument to explain the gender wage gap is occupational segregation based on sex, which means that "large numbers of women are employed in 'female-dominated occupations' on relatively low wages" (Hori 2009: 5).[12]

Factors that enforce a certain degree of gender inequality on the current Japanese labor market are related to both institutions and persistent ideologies. They comprise the weakness of the legal framework, insufficient conditions for achieving a work-life balance, and constraints based on attitudes. These features are deeply connected and impact each other.

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10 On the gender stratification of Japanese society, see Brinton (1988), for example.

11 This is roughly equivalent to an annual income of 30,000 euros.

12 Hori shows that occupational segregation in Japan is high and also seems to be rather fixed. This alone, however, is not a sufficient explanation of the gender wage gap (2009: 16). Yet it is also remarkable that "both women's and men's wages decline as the female share of employment in an occupation increases" (Hori 2009: 16). On the problem of occupational segregation on the grounds of gender, also see Shuto (2009).

The enactment of the Equal Employment Opportunity Law (EEOL, *Danjo koyō kikai kintō-hō*) in 1985[13]—a law that prohibits discrimination based on gender in various stages of employment (Yamada 2009: 197–202)—was a milestone in tackling gender inequality in the Japanese labor market.[14] Before 1985, the number of working women was on the rise due to restructuring of the labor market, but women were most often kept in assistant positions and excluded from benefits such as increasing wages in terms of seniority or life-long employment (Ōmori 1993: 91).[15] The shortcomings of the legal framework are still obvious today. It is particularly the lack of obligatory rules and control mechanisms to keep employers in check that weaken the legal framework. Also, in employment reality, even though career tracks are offered without making a nominal gender-based distinction as a result of the law, many women still find it difficult to apply for managerial-track positions, because this would lead to them being transferred to other branches at some point. The prospect of having to face a transfer—and this is clearly connected to problems caused by inadequate conditions for achieving a work-life balance and by attitudes based on gender roles—poses a huge problem for women, because they are still expected to shoulder most of the childcare and housework due to the mindset widely prevalent in Japanese society (COGEB 2011).[16]

Achieving a work-life balance is immensely difficult for full-time employees. Although women do not necessarily face the structural need to quit their employment after childbirth anymore due to the Childcare Leave Law (*Ikuji kyūgyō-hō*),[17] many women still temporarily drop out of the workforce after giving birth and re-enter the labor market later on as part-timers.[18] Nowadays, many women re-enter

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13 Revisions of the EEOL followed in 1997, 1999 and 2007.

14 The EEOL purposes "to promote equal opportunity and treatment of men and women in employment and it prescribes measures to be taken by employers with regard to 1) recruitment and hiring; 2) assignment and promotion; 3) training; 4) fringe benefits; and 5) mandatory retirement age, resignation, and dismissal" (Ōmori 1993: 90).

15 Since the 1970s, restructuring of the labor market has resulted in a visible expansion of female employees in the commercial and service sector (Ōmori 1993: 81). In 2010, more than 80 percent of working females were employed in this sector compared to 62.7 percent of men (COGEB 2011).

16 Besides the EEOL being a toothless tiger, another structural reason for spouses to decide on a housewife model is inherent in Japan's tax system. If one spouse does not keep their income below the taxable income level, the couple is no longer entitled to benefits such as the spousal company allowance from the (male) breadwinner's company. The pension system also offers financial advantages to couples with male breadwinners and dependent wives (Ōmori 1993: 87–88; *Japan Times* 2010/07/06, 2011/10/23).

17 The Childcare Leave Law (1992) stipulates that women *and* men are both entitled to take childcare leave. However, recent data have shown that the average number of women quitting work upon the birth of their first child was still as high as 41.3 percent in 2000 to 2004, while only little more than 24 percent of women kept their jobs after their first birth (COGEB 2011). In contrast, the number of fathers taking childcare leave is still very low (namely a mere 1.38 percent in 2010) (MHLW 2011).

18 In Japan, part-time work should not necessarily be equated with shorter working hours, but means an irregular form of work within the "flexible and cheap labor force" (Ōmori 1993: 86). Although

the job market once their children have reached an age where they can look after themselves, but most often on irregular work or part-time jobs. One of the most pressing problems of the current Japanese labor market is the widening gap between regular and non-regular employment that goes hand in hand with growing income disparities (Suzuki 2007: 19). The number of women in irregular employment is high in Japan: in 2010, almost as many women worked part-time (41.2 percent) as women who were regular employees (46.2 percent). Add to that women in other irregular forms of employment, such as temporary workers (12.6 percent), and the actual number is even higher. On the other hand, 81.1 percent of the male workforce has been found to be in regular employment (COGEB 2011). The main reason for women deliberately choosing part-time employment is the difficult task they have of shouldering both their family duties and employment.[19]

Women are still in charge of managing the lion's share of family and household duties. This continuing existence of biased gender roles—with women in the workforce facing increasing societal acceptance, but men who focus on familial responsibilities and reduce their working time accordingly often being frowned upon—points to attitudes and ideologies concerning gender equality that are only changing slowly.[20] Attitudes or ideologies that prevent women from striving for career tracks and keeping their jobs after having a child and that prevent men from seeking more involvement in household matters and childcare can be found among female and male employees themselves, among employers, and within Japanese society in general. Despite the implementation of gender-equality policies like the Basic Law for a Gender-equal Society (*Danjo kyōdō sankaku shakai kihon-hō,* 1999), which promotes the idea of a work-life balance and individual solutions regardless of former gender roles, reality still lags behind.[21] Put in an international perspective, the share of Japanese who are convinced that it is best for women to stay at home and look after their children while their husbands go out to work is very high (Suzuki 2007: 16): while the support rate stood at 70 percent in 1979, it was still hovering at around 41 percent in 2009 (COGEB 2011).

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women often work part-time, and although the treatment of part-time workers is very different from that of regular workers, this topic is not covered by the EEOL (Yamada 2009: 204).

19 Anthropologist Glenda Roberts (2011) shows us how Japanese mothers working full-time struggle to cope with their familial and occupational responsibilities. Even if their husbands try to be supportive (Roberts 2011), the average time Japanese men spend on childrearing or housework is very low (Suzuki 2007: 15–16). For further reading on the problem of achieving a work-life balance in Japan and its implications for women's lives, see Inaba (2007).

20 These thoughts come close to what sociologist Arlie Hochschild has pointed to with her term "stalled revolution" (Hochschild 1989, quoted in Inaba 2007: 34).

21 For problems related to the implementation of the Basic Law for a Gender-equal Society, see Holdgrün (2011a, 2011b, forthcoming).

4.2 Gender and Japan's Health-Care Sector

When focusing on health-caregiving for the elderly, we need to keep three types of caregivers in mind: In the private realm, members of the family were and still are important caregivers. As for the labor market, non-profit organizations and for-profit agencies both act as providers of health-care services (Abe Auestad 2009: 210). While this section will consider the gendered structure in the Japanese health-care sector, we shall shed some light on gendered health care within the family first before focusing on the labor market segments of for-profit and non-profit health-care providers.[22]

Despite the institutional and ideological changes and persistence regarding gender equality in Japan's labor market—which we sketched in the previous section—and despite the ongoing socialization of care, which could open up opportunities for a gender-related policy change, all three types of caregivers show a heavily gendered imbalance: 70 percent of caregivers in the family and 80 percent of caregivers in the workforce are women (COGEB 2011).[23]

Health-caregiving in Japanese families has always been a highly gendered issue: female spouses, daughters, and daughters-in-law are still the principal caregivers today. Taking care of elderly family members used to be regarded as the female family members' natural duty. In addition, "it has been assumed that women are not only the normative caregivers, but are the most competent" (Harris and Orpett Long 2000: 258). Normative perceptions like these went hand in hand with women being confined to assistants' jobs on the labor market in general. A woman's first priority was said to be family chores (Orpett Long 2000: 5). The former "Japanese-style" welfare model (*Nihongata fukushi shakai*) that existed before introducing the LTCI system strongly relied on this gender-biased division of responsibilities (Campbell and Ingersoll-Dayton 2000: 245). The effects of this are still visible today. On the other hand, men who take on the role of the familial caregiver are considered "non-normative" (Harris and Orpett Long 2000: 249). Nevertheless, their number is on the rise (Saito 2009: 171–172).

The Japanese volunteer sector is—generally speaking—overwhelmingly female.[24] Frequently, housewives take on an active role in volunteering once their child-raising years are over. This is especially the case for volunteers in the health-care sector, who are most often female. Sociologist Kiyoshi Adachi (2000: 199) tells us that "more than 90 percent of the people who took part in home care services were

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[22] On the background of the socialization of care and gender in Japan, also see Peng (2002).

[23] This is in line with international trends. The majority of health-caregivers around the world are female (Roberts and Group 1995: XIII).

[24] On the role of volunteerism seen against the backdrop of demographic change and social policies in Japan, see Ogawa (2008: 730), and on the role of neighborhood associations and their associated subgroups, such as women's associations (*fujin-kai*), see Pekkanen and Tsujinaka (2008).

housewives" with "an interest in social welfare" (2000: 199). Political scientist David Potter showed in a case study on Aichi prefecture that the average member of health-care NPO for the aged is middle-aged and female. He suggests that these women use the structure of NPO to strengthen community ties (Potter 2008: 701).

We see a similar gendered pattern when it comes to for-profit health-care agencies. According to data in the *White Book on Gender Equality* (*Heisei 23 nenban danjo kyōdō sankaku hakusho*, COGEB 2011), the number of people employed in the for-profit medical and social welfare sector between 2002 and 2010 increased dramatically by 1.8 million. More than two-thirds of these newcomers were women. Similarly, the *Annual Report on the Labour Force Survey 2010* shows that 6,530,000 persons were employed in the Japanese medical, health-care, and welfare sectors at the time. The female share—consisting of 4,950,000 employees—is overwhelming, while only 1,580,000 of them were male. The *Labour Force Survey 2010* shows quite a similar distribution when it comes to medical and other health services: out of a total of 3,420,000 employees, 2,510,000 were women and 910,000 men. We can find a comparable outcome in the field of social insurance and social welfare: 2,380,000 employees out of a total of 3,010,000 were women and 630,000 are men (MIAC 2010).

Looking behind the statistical data enables us to gain more of an insight into the structure of this gender bias within the health-care business sector. Ken'ichi Kobayashi's analysis (2004) of a survey on employees in the caregiving sector shows that the share of women (84 percent) was very high compared to the male respondents (16 percent). It also makes clear that the number of non-regular employees in the caregiving sector was higher in the case of female employees than that of male workers. Interestingly, when it comes to age, Kobayashi points to a reverse M-curve (*henkei shita M-kei bunbu*) in the case of the female caregivers: only twelve percent of the female employees are young women in their late twenties, but the share of female caregivers between 40 and 55 years of age is very high. This is a contrast to the "regular" M-curve, which peaks in the case of young working women.[25] On the other hand, the study illustrates that the young women often worked for caregiving institutions (*shisetsu kaigo*), while the older, middle-aged women were appointed to home-care services more frequently (*zaitaku kaigo*). As will be shown in the following sections, a similar interconnectedness between the carers' age and workplace can be observed on the level of migrant care workers. Migrants working in home-care services are usually middle-aged women. Home-

[25] The "M-curve" shows the female labor force participation pattern in Japan by age: After a peak of the women's share in employment in their late twenties, the figures decline significantly in their early thirties due to child-rearing activities and rise again in their forties. Recent data in the White Book on Gender Equality also show that the middle part of the M-curve is flattening more and more which suggests that Japan is heading in the direction of a reversed "U-curve" without a sharp drop due to years of child-rearing (COGEB 2011).

caring seems to be a classic second career. Kobayashi also showed that male caregivers, however, were mostly in their late twenties; very few of them were any older than that. In total, female caregivers between 40 and 54 years of age made up 90 percent of all the caregivers at the time, according to Kobayashi's 2003 survey. They were both regular and irregular workers (Kobayashi 2004: 42–43). Thus, the health-care labor market is one characterized by "female-dominated occupations" with comparatively low wages, as Hori (2009) points out.

Focusing on the health-care sector in particular allows us to conclude that employment in Japan is in the process of becoming "feminized" due to ongoing institutional and ideological changes. Female participation in the labor market has become much more common, and the quality of female labor is changing slowly, too. Yet ideologies that claim reproductive work such as child-rearing and elderly care should remain a predominantly female duty are prevalent to this day. This is also reflected in the employment statistics in the domestic labor market of health-care work. In other words, gender ideologies are currently shifting from the private realm of the family to the labor market sector of health care. They are also about to impact the third major trend in the profession in addition to the socialization and privatization of health care, namely its internationalization.

5. Ethnicity in the Health-Care Labor Market

Once health care in a society is no longer understood as being part of reproductive work that has to take place within the family, the question of who else cares immediately arises. As was shown in section three of this paper, the problem of manpower in health-caregiving is an obvious flip side to the introduction of the LTCI system. In an interview held in 2006, the Senior Vice Minister of Justice at the time, Tarō Kōno (2005–2006), stated that the first measure to counter any labor shortage in Japan should be to increase the amount of female participation in the workforce and the participation of young people, in particular the so-called "NEET" (*N*ot in *E*mployment, *E*ducation, or *T*raining), rather than to seriously consider international labor migration to Japan (Kōno 2006/02/20). Since then, the discourse on the subject has seen substantial diversification and evolved in directions that are sometimes highly surprising to students of Japan's migration policy, and ranging as far as Hidenori Sakanaka's policy paper that proposes the acceptance of ten million migrants by 2050, preferably young foreigners who were educated at Japanese universities (Sakanaka 2009). In order to contextualize and assess this ongoing discourse on desired or undesired labor migration to Japan, the following chapters will introduce the role international migrants already play in Japan's labor market in general and the health-care sector in particular. The gap between policy output and policy outcome in the field of migration policy and the impact this discrepancy has had on Japan's domestic labor market are of special interest in this study.

5.1 International Migration and Japan's Labor Market

Japan is a country that is still economically powerful despite it encountering a number of setbacks over the past two decades (IMF 2012/01/24). In addition to this, it is politically stable and a country of high public safety. Many of its neighbors in the region are far less so. Put differently, there are many incentives for people from less advantaged countries to move to Japan and look for work there; in a nutshell, this is the push/pull model of international labor migration. The model is not uncontested, in particular because it (almost) solely attributes the decisive power of shaping international migration flows to economic factors. Political scientist James Hollifield (2000) has long argued that the state's influence needs to be studied more thoroughly when aiming to understand how international migration flows are being shaped. The case study of Japan proves him right.

The number of registered foreign residents living in Japan currently stands at 2,134,151 persons, which amounts to 1.67 percent of the total population (MOJ 2011b: 19). Compared to other OECD nations, that is nations with a generally high pull factor regarding global migration, the number and share are both outstandingly low (OECD 2011). They have doubled over the course of the past two decades, however. The number rose from 1,075,317 persons in 1990, and the share rose from 0.87 percent that same year (MOJ 2011b: 19). The growth of Japan's foreign population is an immediate result of the 1990 revision of the Immigration Control and Refugee Recognition Act (ICRRA, *Shutsunyūkoku kanri oyobi nanmin ninteihō*), which opened two "side doors" to labor-related international migration to Japan. These were (a) simplified access to resident and work permits for people of Japanese descent (so-called *nikkeijin*), most of whom migrated to Japan from Brazil; and (b) the expansion of the "trainee" (*kenshūsei*) program, which in its unofficial policy outcome opened the low-wage labor market to young migrants from China in particular (Behaghel and Vogt 2006: 122–130).[26]

(a) The number of Brazilians in Japan rose sharply from 56,429 in 1989—the year before the ICRRA revision—to its peak in 2007 when 316,967 Brazilians resided in Japan. The economic downturn of 2008/2009 resulted in a significant return migration of Brazilians (Rau and Vogt 2009), and by 2010 their number had dropped to 230,552 persons (MOJ 2011b: 20).

(b) The Chinese population in Japan has seen a pronounced numerical increase for two decades now. It stood at 150,339 persons in 1989 and rose to 687,156 persons in 2010, surpassing the Koreans as the largest ethnic minority in Japan in 2007 (MOJ 2011b: 20). While the Chinese population in Japan is highly heterogeneous (LeBail

[26] Ippei Torii, head to the Zentōitsu Workers' Union based in Tokyo, is one of the most outspoken critics of Japan's *kenshūsei* program. He reports about hourly wages of around 300 yen (roughly three euros) and other extreme hardships that migrants have experienced at work (Torii 2007/10/23).

2011; Liu-Farrer 2011), it should not go unnoticed that more than half of all the participants in the trainee program in Japan were Chinese; their number alone peaked at 68,860 persons in 2008. By 2010, though, after an extended period of economic downturn, it had fallen to 28,964 persons (MOJ 2011b: 11).

The numerical decline of both the Brazilian and the Chinese populations in Japan over the course of the economic downturn tells us a story of the vulnerability of low-skilled foreign workers in Japan's labor market. While the Brazilian workforce became famously important to Japan's manufacturing sector,[27] among the Chinese it has been the workers in the shadow labor market of the trainee system who have experienced economic hardship most directly. This reflects what political scientist Takashi Kibe (2011: 61) calls the utter failure of a "workforce-oriented move" in Japan's socio-economic integration policy with respect to foreign workers.

While these two "side doors" of international migration to Japan over the past decades have resulted in a significant influx of foreign workers on Japan's domestic labor market, the "back door," that is the entrance portal to Japan's labor market for irregular migrants, has been shut fiercely by the Ministry of Justice (MOJ).[28] In the early 1990s, immediately after the ICRRA revision, the number of irregular migrants rose sharply—from 159,828 persons in 1991 to 298,646 persons in 1993. Ever since then, it has seen a steady decline and was down to 78,488 persons in 2011 (MOJ 2011b: 34).

As far as the issue of "front-door" access to Japan's labor market for international migrants is concerned, it should be noted that Japan's migration policy has been characterized by "exclusively highly skilled migration" and "exclusively short-term migration" for many years now. The ICRRA defines 27 visa categories today (§2 II and §19), 17 of which include a work permit for a specific designated activity, such as working as a journalist, artist, or engineer, and indeed many more professions generally taken up after doing a tertiary degree. Officially speaking, due to the lack of an appropriate visa category, unskilled international workers (*tanjun rōdōsha*) are excluded from working in Japan by law.

In addition, five visa categories allow for an unconditional work permit in Japan, regardless of whatever professional skills the applicant possesses. These are the following, with the number of holders in 2010 included in brackets (MOJ 2011b: 21):

[27] See the ethnographic studies by Roth (2002) and Tsuda (2003), for example.

[28] For a brief account of the MOJ's campaign against irregular migrants to Japan, see Vogt and Lersch (2007: 280–281), for example.

- Permanent resident (*eijūsha*) (565,089 persons)
- Special permanent resident (*tokubetsu eijūsha*)[29] (399,106 persons)
- Spouse or child of a Japanese national (*Nihonjin no haigūsha*) (196,248 persons)
- Spouse or child of a permanent resident (*eijūsha no haigūsha*) (20,251 persons)
- Long-term resident (*teijūsha*) (194,602 persons).

As a result, in 2010, 1,375,296 persons held a visa that did not impose any restrictions on their work permit and allowed for permanent or at least long-term residency in Japan. This constituted 64.44 percent of all foreign nationals in Japan at the time, which means that two-thirds of Japan's foreign population did not necessarily comply with Japan's migration policy output. This significant gap between policy output and policy outcome is a result of three trends: First, Japan's colonial history; secondly, its *jus sanguinis* policy, which values blood relations more highly than concepts such as denizenship or local citizenship (Tsuda 2006); and thirdly, perceived economic necessities, brought into the migration policy discourse via the Ministry of Trade, Economics, and Industry (METI) and the Japan Business Federation, *Keidanren*, for example.

Migration scholars Wayne Cornelius and Takeyuki Tsuda (2004: 6) tell us that "'unintended consequences' of immigration control," such as the policy gaps outlined above, "may not be so unintended, or may be in fact fully intended."[30] They may simply serve as a delicate tool of immigration control catering to economic needs and societal fears alike, and thus prove extremely convenient for the policy-makers. The reality of Japan's labor market is that while only highly skilled labor migrants are allowed onto the market, many medium- and low-skilled migrants who legally reside in Japan due to them being, for example, spouses of Japanese nationals can legally be employed as foreign workers, too—and they often are.

5.2 International Migration and Japan's Health-Care Sector

As a labor market segment, Japan's health-care sector ties in with the line of thought elaborated upon in the section above, in particular through two aspects: on the one hand, it serves as an example of a labor market segment consisting of medium- and

[29] This visa category is reserved for foreign nationals who were living in Japan before it regained its state sovereignty in 1952 and their descendants. Most special permanent residents are of Korean or Taiwanese origin and came to Japan—often as forced labor—during the period of colonization of their regions of origin by Japan. In today's migration literature, they are referred to as *zainichi* (residing in Japan).

[30] For a more thorough elaboration on the "unintended" character of Japan's migration policy gap, refer to Vogt (forthcoming), for example.

low-skilled professions, which has also been filled with foreign workers for some years now; and on the other hand, this particular sector is part of a highly dynamic policy reform, which has the potential to bridge the vast gap between policy output and policy outcome in Japan's migration policy by actively recruiting medium-skilled workers from abroad and opening up a long-term settlement perspective in Japan through what are known as Economic Partnership Agreements (EPA). Besides trade and tariff regulations, these bilateral treaties also include the movement of "natural persons" as part of intensified economic cooperation. So far, such agreements covering the movement of natural persons have been put into effect between Japan and the Philippines (May 2009) and between Japan and Indonesia (August 2008).

Filipinos in Japan constitute the fourth-largest group of foreign nationals. In 2010, there were 210,181 Filipinos residing in Japan, up from 49,092 in 1989 (MOJ 2011b: 20). After the Chinese and Brazilians the Filipinos with 116,228 (in 2009) *eijūsha* come in third in terms of the number of permanent residents in Japan (MOJ 2011b: 21). The number of Filipinos on a "spouse of a Japanese national" visa in 2009 amounted to 46,027; the number of Filipino long-term residents in Japan stood at 37,131 persons in 2009. In contrast to these figures, the Indonesians in Japan constitute a much smaller group: 3,462 permanent residents, 2,854 spouses of Japanese nationals, and 1,774 long-term residents, among others (MOJ 2011a: 100–101). Due to the sheer numerical importance that the Filipinos possess in relation to the rest of Japan's migrant body, and also due to the specific standing of the Philippines as a nation that prides itself in being a labor exporter, in particular in the health-care sector, and celebrates its emigrants as significant contributors to the nation's gross domestic product (Kingma 2006; Tigno 2009),[31] the paper at hand will put a certain focus on the migrant group of Filipino health-caregivers in Japan.

Holders of the visa categories mentioned in the paragraph above are not subject to any restrictions with regard to work permits in Japan. A fair number of Filipinas enrolled at private educational institutions in order to obtain training as a home helper and/or care worker there. In fact, the students from the Philippines who were interested in attending such courses were overwhelmingly women. The first school of this type catering particularly to the Filipina clientele—who as longtime residents to Japan often have a good command of spoken Japanese, but sometimes have problems with written expressions—opened in Tokyo in 2004. A school in Nagoya followed in 2005, and another one opened in Osaka in 2006 (Virag 2008: 10). In addition, 1,868 Filipinos are estimated to have graduated from non-ethnic training centers so far (Ballescas 2009: 132). With the group of certified care workers from the Philippines growing, they soon founded their own labor organizations: 50

[31] Since 2000, the average annual remittances of migrant workers from the Philippines have amounted to ten percent of the nation's gross domestic product (Tigno 2009: 28).

members in Nagoya founded The Licensed Filipino Caregiver Association of Central Japan in 2005. The Licensed Filipino Caregiver Association in Japan (LFCAJ) followed in 2006 in Tokyo with 100 members initially, all of whom possessed a home helper license (Ballescas 2009: 132; Virag 2008: 11).

LFCAJ strategy back then was to remain as small and intimate a group as possible, catering only to the immediate needs of its members and clearly not interfering in the policy-making process on labor migration to Japan itself.[32] Judging from their professional website and the information that is presented there, the LFCAJ has not only started collaborating with the quasi-governmental Philippine Overseas Labor Office, located in the Philippine Embassy to Japan in Tokyo's Minato Ward, but also seems to have expanded its focus of engagement to include networking activities within the Filipino community in general (LFCAJ 2012).

Following the first group of Indonesian health-caregivers who came to Japan under the EPA-administered migration scheme in August 2008 and were portrayed vividly by the Japanese media (*Nihon Keizai Shimbun* 2008/08/07), the first group of health-caregivers from the Philippines arrived in May 2009. The labor migration of nurses and health-care workers from both countries—who are subsumed under the term "health-caregivers" in this paper—was made possible through bilateral EPA that Japan signed with the Philippines in 2006 and with Indonesia in 2007. Both EPA stipulate that 1,000 health-care workers per year and per nation were to be granted access to Japan's domestic labor market (MOFA 2012a, 2012b).

Candidates willing to work in Japan need to undergo preliminary screening in their home countries conducted by the Japan International Corporation of Welfare Services (JICWELS, *Kokusai kōsei jigyō-dan*), a quasi-governmental organization bound to the MHLW. JICWELS screens the candidates for degrees and work experience according to their job applications and conducts interviews with them. JICWELS is also in touch with hospitals and care institutions in Japan that apply to take in migrant health-care workers under the EPA. The organization is therefore in charge of matching the candidates to prospective employers. Upon their arrival in Japan, the health-caregivers enroll in an intensive six-month Japanese language course, which is sponsored by the Association for Overseas Technical Scholarship (AOTS, *Kaigai gijutsusha kenshū kyōkai*), yet another quasi-governmental organization that is bound to the Ministry of Economy, Trade, and Industry (METI).[33]

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[32] This information is taken from numerous e-mail conversations with an LFCAJ representative in 2008 and a personal interview with an academic advisor to the group in 2009 who both asked to have their identity protected.

[33] Interestingly enough, AOTS is funded via Japan's budget for Overseas Development Aid (ODA) and also the organization administering the highly contentious trainee system (Vogt 2011: 331).

After successfully completing their preliminary language education, health-care workers are dispatched to the institutions where they will receive on-the-job training as assistant health-caregivers, no matter what professional degree they have already obtained. After living in Japan for three years (in the case of nurses) or for four years (in the case of health-care workers), the candidates are required to take Japan's national examinations in the various occupations. Those who pass are allowed to stay on in Japan with a longtime perspective: indefinite resident permits for Indonesians and renewable multi-year visas for Filipinos. Those who fail the exam see their work visas revoked. So far, only a very small number of candidates have managed to pass the exam, with spring 2012 seeing the highest figure until now, namely 36 candidates, that is 37.9 percent of all applicants (*Japan Times* 2012/03/28).

While it is still strikingly low, the number of successful applicants has risen significantly compared to the two preceding years. This increase is taken to be an immediate result of a government decision to include *furigana* characters in the exam texts, thereby making the texts easier for non-native speakers of Japanese to understand (*Daily Yomiuri Online* 2012/01/05). Since the implementation of the system, employers and employees[34] alike have perceived language to be a major hurdle responsible for the low success rate of applicants, a fact expressed, for example, by 60.8 percent of managers of health-care facilities interested in hosting health-care migrants (Kawaguchi, Hirano and Ohno 2009: 55).[35] The nursing skills of the health-care migrants, on the other hand, have been an issue of much less concern to the employers, with only 47.0 percent of them referring to these when explaining their reluctance in employing health-caregivers from the Philippines or Indonesia (Kawaguchi, Hirano and Ohno 2009: 55). Yet on numerous occasions the Philippine Association of Nurses has expressed its concern about the fact that Philippine nurses are treated just like trainees in Japan and are obliged to have their language proficiency tested despite being nursing professionals who are welcomed all over the world and who could earn a reasonable amount of money in the United States as soon as they had found employment (Asato 2007: 39–42; Shimada 2009: 263).

Migration policy—in Japan and in several other countries as well—is a policy field that is not under the guiding administration of one government body; rather, it is situated at the intersection of vastly different policy fields, most prominently, labor and welfare policies, economic policies, and security policy. Not surprisingly, several key actors aim at shaping Japan's migration policy output, including the

[34] For a data-rich qualitative study on the employees' view of the language hurdle, see Setyowati *et al.* (2012), for example.

[35] For a full English language account of this survey data on Japanese hospitals' stance on migrant health-care workers, which was compiled by a research team from Kyushu University Asia Center in 2008, see Vogt (2011).

MHLW, the METI, and the MOJ as well as several lobbying groups from the labor and business world, such as the Japan Nursing Association (JNA) and *Keidanren*. The outcome of their deliberations,[36] that is the EPA-administered migration scheme in its current form, has by no means remained uncontested in Japan. In particular, the most critical part of the system, namely the necessity to pass the national professional examinations in Japanese, was included in it only after strong lobbying from the JNA, which was able to influence the deliberations through the MHLW. The official version states that labor standard protection was at the heart of the JNA's concerns; probably at least of equal importance in the deliberations was the protection of the labor market itself, which was advocated by the MHLW (Vogt 2007).

In fact, an EPA is the first nation-specific and job-specific migration avenue open to international labor migrants to Japan, opening yet another "front door" in international labor migration. However, this obviously runs counter to Japan's two main official pillars of its migration policy, which are to grant work permits exclusively to the highly skilled and to grant resident permits exclusively on a temporary basis. The section above has clarified that Japan's migration policy output is a far cry from the actual outcome of its policy. The EPA-administered migration scheme has actually been the first one to attempt to achieve an output that is coherent with the outcome of migration policy and bridge the prevailing structural gap between the two. Its aim has been a high one, but so far it has been unable to realize any substantial policy reform, let alone turn this reform from regulations set down in bilateral treaties into written law, which would find its place in the ICRRA. In attempting to draw a preliminary conclusion on the impact that the EPA migration scheme has had on Japan's health-care sector, we feel it needs to be classified as a system that supports the shift from unpaid to paid health-care work—albeit in small and economically insignificant numbers—yet it has failed to reform Japan's migration policy and/or welfare policy to date.

6. Intersectionality in the Health-Care Labor Market

As the socialization, privatization, and internationalization of the health-care labor market proceeds, an opportunity has arisen for a substantial policy change in this sector of Japan's labor market. As outlined in the paragraphs above, with regard to migration policy, the change that followed the window of opportunity, which presented itself in the course of these three processes, fell short of turning into a comprehensive reform. So far, it has remained an exclusive, single-sector, treaty-based agreement with two nations[37] rather than evolving into a substantial reform of

[36] See Vogt (2007), for example, on the process of the EPA deliberations in Japan's domestic politics.

[37] In spring 2012, Japan and Vietnam agreed on a similar avenue for EPA-administered migration of health-care workers to Japan. In addition to caregivers from the Philippines and Indonesia, the first

the ICRRA. Such a reform would mean Japan faced the necessity of accepting labor migrants as one measure to counter the trend of an ever-declining workforce. Japan is clearly not doing this, however. It is still tampering with a migration avenue that envisages very low quotas to start with, and due to its low attractiveness for migrants, it is not even able to achieve these.

Another area where EPA fall short of their potential is in overcoming the gender-division in the health-care labor market in Japan. In fact, they actually reinforce the gender roles in the sector, with the overwhelming majority of health-care migrants being female. For example, in the process of matching the first group of Indonesian migrant candidates and their future employers in 2008, 86 candidates were unable to be matched. This produced something of an uproar in Japan's English-language press when it later turned out that 66 of these 86 candidates were men (Brasor 2008/08/17; Kobayashi and Sato 2008/08/01). While 40 percent of the health-care workers in the first group of Indonesians were in fact men, the picture portrayed in the Japanese press was vastly different, as Philip Brasor (2008/08/17) observes,

> [...] the visual emphasis on the feminine, not to mention the repeated use of adjectives like "kind," "cheerful," and the ubiquitous "smiling" to describe these women, conveyed the impression that they were Florence Nightingales coming to Japan with the purest charitable intentions to comfort its aging population.

In public discourse, the picture of the natural health-caregiver being a female one is still very much alive in Japan. As political scientist Reiko Ogawa (2008: 9) put it, the EPA added a "racial division to reproductive labour without challenging the current gender order." The EPA challenges neither the portrayed gender order nor the one being maintained at the workplace. While the content of the policy programs related to the LTCI and the EPA programs is gender-neutral (MOFA 2012a; MOFA 2012b), many heads of nursing homes and hospitals clearly prefer female employees. As one head of a nursing home in the city of Sendai confidentially mentioned to one of the authors in 2008, ethnic difference alone was already quite a unique feature among health-caregivers, and it was basically unthinkable to employers to add yet another unique feature to ethnicity, namely a different gender from the one Japanese patients have so far encountered in most of their health-caregivers. With regard to the intersection of gender and ethnicity in the health-care labor market, obviously a "deviation from the norm" could only be tolerated in one of these dimensions, not in both of them—if at all. At least, this is what this employer thinks about (and probably others, too) when considering the composition of their staff.

With the internationalization of the health-care labor market—albeit in small numbers—we actually face a mechanism that brings gender (back) into the picture.

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group of Vietnamese health-care workers is expected to arrive in Japan in 2014 (*Japan Times* 2012/04/20).

Despite a gender-neutral policy output, the outcome shows that Japanese institutions and ideologies remain highly gendered and as such impact migration patterns as well. This fits into the pattern Gaetano and Yeoh (2010: 2) call "a global division of labor including reproductive labour or care work" and shows how gender ideologies "structure [...] labor recruitment patterns." Gender and ethnicity are highly intertwined in Japan's health-care sector.

Let us add another perspective now by considering the home helper segment of the health-care labor market. Sociologist Leslie McCall's (2005) concept of intracategorial differences in the labor market can be identified within the group of Filipina health-caregivers in Japan. In 2008, representatives of the LFCAJ stated in confidential conversations with one of the authors that they expected some rivalry to occur between various groups due to the future influx of health-caregivers from the Philippines under the EPA scheme: on the one hand, the longtime Filipina residents—some of whom in fact came to Japan in the 1980s on "entertainer" (*kōgyō*) visas and worked in the red-light districts of Japan's major cities, then got married to Japanese men and stayed on—who were now trying to earn a new living from a second career in a respectable profession; and on the other hand, the young newcomers fresh from nursing school, who are well educated and tend to look down on those who came to Japan before them.

Another reason for potential social stratification between the two groups that the informant mentioned was their workplaces. While the earlier migrants mostly have less-skilled jobs on the home helper market, the newcomers enter the more prestigious institutional care facilities. This division of labor reflects the current division among the native Japanese health-caregivers: young caregivers fresh from school mostly work in institutional care, while health-caregivers over the age of 40 who return to their old profession after a long period of absence due to childrearing choose this particular profession as a second career path—and often find part-time work in the home helper sector (Kobayashi 2004: 42–43). Age obviously comes into play here as yet another category of importance when studying interdependencies in the health-care labor market. The wage level is another point of concern, as caregivers earn comparatively low wages. Thus, the persistence of the gendered structure of this labor market segment contributes to the persistence of the gender wage gap in terms of occupational segregation based on sex, as Hori (2009) has shown.

Policy programs regarding the ongoing socialization, privatization, and internationalization of care work in Japan have opened up opportunities for employment regardless of gender, yet this has not resulted in a shift to a gender-neutral labor market. On the contrary, the Japanese health-care labor market is still heavily gendered, and social change regarding the gender dimension clearly is not among the outcomes of the policy change. Migration patterns are feminized and intersect with each other, just like the situation in this segment of the labor market.

7. Conclusion

This paper has framed Japan's health-care labor market in terms of the interdependencies of categories of difference. It has addressed the impact and interdependencies of differences on the macro level of social structures and institutions. The categories of gender and ethnicity are strongly connected to each other in the sector of health-care work in Japan. While demographic challenges and a severe labor shortage paved the way for a shift in Japan's migration policy, the policy outcome did not include a shift to a gender-neutral labor market segment. While the policy output is gender-neutral in its programs, a strong gender bias prevails in the recruitment demands of health-care institutions in Japan. In an intracategorial view, differences between newly arrived health-care migrants from the Philippines and residents who had entered Japan some forty years prior to them also became obvious. The divided pattern of employment in health-care facilities and as home helpers is also related to the age structure that put middle-aged women in different positions—in general in a lower wage and lower prestige segment in the labor market—compared to those of young health-care workers.

The health-care labor market in Japan intertwines categories of gender, ethnicity, and differences between ethnic groups in a multifaceted way. While this paper has focused on the macro level of institutions and, to some degree, on the level of representation in terms of ideologies, further research that elaborates on case studies of the micro level may provide some additional insights into the mechanisms of how and why gendered structures persist when it comes to employment patterns in the health-care labor market.

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