

**The international recruitment of healthcare
workers in Japan and Norway:
A case study**

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Thesis submitted as a part of the Master of Philosophy
Degree in Health Economics, Policy and Management

November 2016

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<http://www.duo.uio.no/>

Trykk: Reprosentralen, Universitetet i Oslo

ABSTRACT

The title of this research project is the international recruitment of healthcare workers in Japan and Norway: A case study. Japan and Norway have a future projection of the shortage of healthcare workers. Since, health services are labour intensive; it is difficult to replace healthcare service with automated service, thus, recruitment of the foreign trained healthcare workers has gained popularity. The international community has raised concerns over the international recruitment of healthcare workers, which is weakening the health system of the source countries. The aim of this thesis is to analyse the similarities and differences in the regulatory frameworks of the international recruitment of healthcare workers between Japan and Norway. It also considers how, and possibly why, those frameworks may affect their working conditions. The research method is a comparative analysis of the international recruitment in two countries. Data used are primarily literature, public documents, statistics extracted from OECD. Stat, the number of ratifications of ILO Conventions, and the result of the National Reporting Instrument of WHO Global Code of Practice on the International Recruitment of Health Personnel. The data are analysed with the help of an analytical framework based on managerialism and marketization from New Public Management (NPM). This study finds that NPM has influenced the regulatory framework of the international recruitment of healthcare workers in both countries. In Japan marketization is a key word, while Norway is more inclined towards managerialism. It appears from the data that the difference in the regulatory frameworks of these countries may influence the working conditions of healthcare workers. The legal protection and the working environment of healthcare workers are defined by the regulatory framework and if it is not in place, the working environment would rapidly deteriorate.

ACKNOWLEDGEMENTS

The work of this study has been an exhausting one, although the subject is interesting, which was made possible through the able guidance and support extended by Professor Frode Veggeland, who enabled me to put the pieces together in a shape of the study. I am grateful that he remained always positive and supportive to my work, which gave me confidence and strength to proceed with this study while working away from Oslo.

The additional support provided by Mr Ivan Spehar, for his advice regarding resources particularly report on the immigration in Norway and his valued comments at the early stage of my work; Professor Takayoshi Amenomori, who suggested several books related to immigration, migrant workers and technical training issues in Japan, from those books I have got a lot of insights; Dr. Amani Siyam provided the results on the National Reporting Instrument of WHO Global Code of Practice on the International Recruitment of Health Personnel in Japan and Norway, which made this study more interesting; Ms Birthe Neset, who has remained an excellent facilitator and kind advisor to all students at Department of Health Economics and Health Management, provided me with a great support during challenging time of my student life. On this page, I would like to pay my sincere gratitude to all those who provided helping hand.

I would like to appreciate friends and family: Sim Hooi Yeoh and Martin Mwamba who extended their kind friendship and support; Mr Ahmed Owais Pirzada and Mrs Aasia Pirzada have prayed for my success in my study; Scott Davey and his family, for their inspiration in my life; and my family in Japan and in Pakistan who rendered their endless love and support and last, special thanks to Ghulam Asghar, who supported me in every respect, from taking care of home to discussing on health system and proofreading of my thesis.

LIST OF ABBREVIATIONS

EEA	European Economic Area
EFTA	European Free Trade Association
EPA	Economic Partnership Agreement
EU	European Union
GP	General Practitioner
ILO	International Labour Organization
ISO	International Organization for Standardization
JICWELS	Japan International Corporation of Welfare Services
LTC	Long-Term Care
MHLW	Ministry of Health, labour and Welfare
NAV	Nye arbeids- og velferdsetaten (Norwegian Labour and Welfare Administration)
NPM	New Public Management
NRI	National Reporting Instrument
OECD	Organisation for Economic Co-operation and Development
PPP	Purchasing Power Parity
SAK	Statens autorisasjonskontor for helsepersonell (Norwegian Registration Authority for Health Personnel)
UDI	Utlendingsdirektoratet (Norwegian Directorate of Immigration)
WHA	World Health Assembly
WHO	World Health Organization

CONTENTS

ABSTRACT 3

ACKNOWLEDGEMENTS 4

LIST OF ABBREVIATIONS 5

1. INTRODUCTION..... 9

 1.1 Japan and Norway: the two ageing societies with burgeoning demand of healthcare workers..... 9

 1.2 Aim and research question 10

 1.3 The structure of the thesis 11

2. THE ANALYTICAL FRAMEWORK, METHODS AND DATA..... 12

 2.1 Analytical Framework..... 12

 2.1.1 New Public Management (NPM) influenced by Neoliberalism..... 12

 2.1.2 The matrix model of NPM effects on recruitment of migrant healthcare workers..... 13

 2.2 Methods and data..... 15

 2.2.1 Statistical data..... 16

 2.2.2 System comparison: Japan and Norway..... 17

 2.3 Limitations 18

3. THE TREND OF LABOUR MIGRATION POLICY ON HEALTHCARE WORKERS: AN OVERVIEW..... 20

 3.1 Global overview of labour migration 20

 3.2 The trend of policies/ legal framework on migrant healthcare workers..... 21

 3.2.1 Reforms inspired by New Public Management..... 21

 3.2.2 Neoliberalism 22

 3.3 The efforts to protect healthcare workers at international level 23

3.3.1 ILO Decent Work Indicator.....	24
3.3.2 WHO Global Code of Practice on the International Recruitment of Health Personnel	25
3.3.3 ISO 26000 Social Responsibility.....	25
3.4 Summary	26
4. THE REGULATORY FRAMEWORK OF MIGRANT HEALTHCARE WORKERS IN JAPAN AND NORWAY	28
4.1 Japan.....	28
4.1.1 Migration Policy Overview	28
4.1.2 Economic Partnership Agreement (EPA) on nurse and certified care worker	31
4.1.3 Framework of receiving candidate as a nurse and care worker under the EPA	33
4.1.4 Situation of the EPA candidate after obtaining a Japanese qualification	37
4.2 Norway	37
4.2.1 Migration Policy Overview	37
4.2.2 Norway's EEA Agreement.....	38
4.2.3 Application process of healthcare workers' authorisation as skilled workers.....	39
4.2.4 Legal status of skilled worker from non-EEA countries	39
4.3 Similarities and differences between the migration system of Japan and Norway	41
4.3.1 Similarities.....	41
4.3.2 Differences	42
5. COMPARISON AND ANALYSIS	43
5.1 WHO Global Code of Practice on the International Recruitment of Health Personnel	43
5.1.1 Results of National Reporting Instrument (NRI) in 2012	43
5.1.2 Results of National Reporting Instrument (NRI) in 2015	45

5.1.3 Main Findings from two surveys of National Reporting Instrument (NRI)	47
5.2 Regulatory framework for the international recruitment of healthcare workers: Japan and Norway	47
5.3 Ratification of ILO Conventions	51
5.4 Statistical data related to workers of Japan and Norway	54
5.4.1 Working conditions of nurses in Japan and Norway	54
5.4.2 General working conditions and labour protection in Japan and Norway.....	56
5.5 Labour laws enforcement	61
5.5.1 Japan.....	61
5.5.2 Norway	63
5.6 Influence by NPM on health policy.....	65
5.6.1 Japan.....	65
5.6.2 Norway	66
5.6.3 Summary of influence by NPM in Japan and Norway	68
6. DISCUSSION	69
6.1 Major findings	69
6.2 The matrix model of NPM effects on recruitment of migrant healthcare workers	71
6.2.1 NPM effects on migrant healthcare workers in Japan.....	72
6.2.2 NPM effects on migrant healthcare workers in Norway	73
7. CONCLUSION	75
REFERENCE LIST.....	77

1. INTRODUCTION

1.1 Japan and Norway: the two ageing societies with burgeoning demand of healthcare workers

Among industrialised countries, Japan and Norway are ageing societies, where the concern is the shortage of healthcare workers. In 2014, the percentage of each country's population over 65 years old in the total population was 26.1% (OECDiLibrary, 2015a) and 16% (OECDiLibrary, 2015b) respectively. Ministry of Health, Labour and Welfare (MHLW) estimated that the 370,000 personnel will be required in addition to the existing workforce in Japan by 2025 (MHLW, 6/24/2015). Japan is struggling with the shortage of healthcare workers such as nurses and certified care workers by their high turnover (MHLW, 2014a, 2014b) While, Ramm (2013) claimed that one fifth of the population in Norway could be older than 67 years old by 2050 and by 2060 the demand for the healthcare workers would reach two-fold increase. According to OECD (2014) estimation, Norway expects the probable decrease of the working population after 2020 due to the recent lower growth of birth cohorts (OECD 2014:31). Although Norway's demographic change to ageing was much slower than Japan as the total fertility rate in 2013 was relatively higher as 1.8 children (OECDiLibrary, 2015b) than that of Japan as 1.4 children (OECDiLibrary, 2015a).

In order to address the above shortfall of health care workers, there are two options; one is to increase the number of locally trained healthcare workers, and the other is to recruit trained healthcare workers from overseas. According to Bach (2003) and Buchan (2002), policymakers consider the international recruitment of healthcare workers as a more convenient way to meet the demand, instead of making efforts, train, recruit and retain healthcare workers locally. One would assume the reason behind this is that the longer period of training and skill development are required to have a highly skilled and specialized workforce. Globalisation, liberalisation and measures aimed at freer movement of services

and workers across borders have made international recruitment a familiar policy option to overcome the healthcare workforce shortage among industrialised countries including Japan and Norway. However, Bach illustrates the concerns of negative consequences due to increased migration even if the recruitment of migrant healthcare workers is well managed (Bach, 2003). This issue is discussed in a later chapter.

1.2 Aim and research question

The recruitment system of healthcare workers from overseas in Japan differs from Norway in its process and the status of recruiting workers on several points. First, Akashi (2011) describes that in principle Japan neither accepts immigrants nor labour migrants with low skills; however, in practice Japan has bilateral agreements, such as the Economic Partnership Agreement (EPA) to bring the foreign labourers (Akashi, 2011), whereas, Norway accepts immigrants and labour migrants (OECD, 2014). Second, the foreign healthcare workers must obtain Japanese qualification to work in Japan (MHLW, 2015), while Norway recognises foreign qualifications of healthcare workers (Helsedirektoratet, 2016).

The aim of this study is to analyse the different aspects of the international healthcare worker's recruitment system in Japan and Norway and seek for the possible explanation of these differences. The automation of the work in healthcare services is difficult as compared with other industries; therefore, it is labour intensive. Although the healthcare workers take pride in their work, the poor working conditions, for example, physical and psychological burden, possible exposure to health risk and the less recognition of their services discourage new entrants, which would lead to the shortage of healthcare workers. The research question will be pertinent here to see the important factor which would influence the regulatory framework and ultimately the working conditions of the migrant healthcare workers in Japan and Norway.

The research questions are stated below: how are the regulatory frameworks for the international recruitment of healthcare workers designed in Japan and Norway, and what are the possible explanations for differences and similarities between these frameworks? In what way can the regulatory frameworks in Japan and Norway affect the working conditions of the migrant healthcare workers?

1.3 The structure of the thesis

This study offers a systematic comparison of the international recruitment of healthcare workers in Japan and Norway. The paper is structured as follows. Chapter two outlines the analytical framework, methods and data in this study. The third chapter provides an overview of the trend of labour migration policy on healthcare workers. The fourth chapter provides a description of the regulatory framework on migrant healthcare workers in Japan and Norway. Comparison and analysis of international recruitment of healthcare workers in Japan and Norway are presented in chapter five. Chapter six discusses findings of this study.

2. THE ANALYTICAL FRAMEWORK, METHODS AND DATA

2.1 Analytical Framework

2.1.1 New Public Management (NPM) influenced by Neoliberalism

According to Larbi (1999), economic and fiscal crises in the 1970s and 1980s raised strong criticism against the failure of old public management among developed countries by the neoliberal ideologists. They questioned against the role and capacity of public administration and emphasised the replacement of the traditional management with a new market-oriented management, which focuses on competition and minimised state intervention (Larbi, 1999). Yoshihara (2009) explained that Japan and Norway were not exceptions from the trend of neoliberal reforms in public management. Japan introduced healthcare reforms inspired by neoliberal ideology in 2001, which achieved historic radical reduction of healthcare costs by 2006 through minimised public administration, market system, regulatory reforms and privatisation (Yoshihara, 2009). Contrary to Japanese market oriented reform, Hagen and Kaarbøe (2006) described that Norwegian health reform had special characteristics of both centralisation and decentralisation as well as public ownership of hospitals. The 2002 hospital reform was notable with three factors as; a) hospital ownership was taken over by the central government from counties; b) the Minister of Health took charge of management of hospitals and c) hospitals were reorganised into independent enterprises governed by a board (Hagen and Kaarbøe, 2006). Forming the autonomous healthcare institutions as enterprises would implicate decentralisation and a part of neo-liberal reform, however, regaining a centralised hospital management by the state would not represent New Public Management ideology. In the light of above, regardless of the degree of influence and the way of adaptation of NPM, neoliberal NPM has reflected in the healthcare system of Japan and Norway. This could possibly have influenced the regulatory frameworks of the international recruitment of healthcare workers in both countries. The regulatory framework of the international

recruitment would possibly affect the working conditions of healthcare workers. Hence, the theoretical perspective of this comparative study assesses as to how NPM has influenced the regulatory framework for the international health worker recruitment and endeavours to see its possible effects on the working conditions of foreign health workers in two countries.

2.1.2 The matrix model of NPM effects on recruitment of migrant healthcare workers

There are two major features in the components of NPM, which emphasise different concepts; one is “a managerial improvement and organisational restructuring (managerialism)” and the other is “markets and competition (marketization)” (Larbi, 1999: 13). As they correspond each other in operation, they could be “*a continuum*” (Larbi, 1999: 13). Through this continuum, operational tendencies either towards managerialism or towards marketization can be observed in Japan and Norway.

It is important to note the effects of NPM inspired reforms/policies of each country by prioritising either equal treatment of healthcare workers or economic efficiency of healthcare system. Du Gay (2000) claims there is a paradigm shift on the governance of the public sector to new management ideologies of neo-liberal NPM from equity based social security policies. Collective equity and equality in society are not compatible for rich countries with economic efficiency (Du Gay, 2000). The above economic efficiency based on individual responsibility is an opposite value with social security and equality. They could be seen as a continuum as well, particularly to observe the tendency of each country’s priority towards either economic efficiency or equitable social security. Change in values can possibly affect the way of policy setting as well as the regulatory framework of healthcare of each country. As a result, they ultimately influence the working conditions of healthcare workforce. For example, if healthcare policy puts its emphasis on economic efficiency of healthcare system, it may need to compromise equal treatment of healthcare workers. On the other hand, if the policy puts its emphasis on equal treatment of healthcare workers, economic efficiency of the healthcare

system might not be significant. Thus, the effects of NPM as equal treatment of the healthcare workers and economic efficiency of the healthcare system also could be seen as a continuum.

For the analytical framework of this study, as mentioned above, two continuums are: first one, managerialism and marketization shown horizontally and the other one, equal treatment of the healthcare worker and economic efficiency of the healthcare system shown vertically to form a matrix. These two continuums crossed at right angle forming four sections where each section is filled with different values representing the effects of NPM. The Matrix model is to assess each country's prioritised policy and the effects on the recruitment system of migrant health care workers. The four dimensions of effects of NPM on recruitment of migrant healthcare workers are: 1) employment protection and 2) open labour market (equal opportunity) on the side of equal treatment of the healthcare workers, 3) monopolistic labour market (unequal opportunity) and 4) employment exploitation on the side of economic efficiency of the healthcare system. By this matrix model, the author would attempt to assess both countries' priorities on migrant healthcare workers recruitment. For this analysis, following data are used in this study: literature, public documents, statistics related to the working conditions of workers, numbers of ratification of ILO Conventions and the result of National Reporting Instrument (NRI) of WHO Global Code of Practice on the International Recruitment of Health Personnel. The matrix model of NPM effects on recruitment of migrant healthcare workers is presented in Figure 1 below.

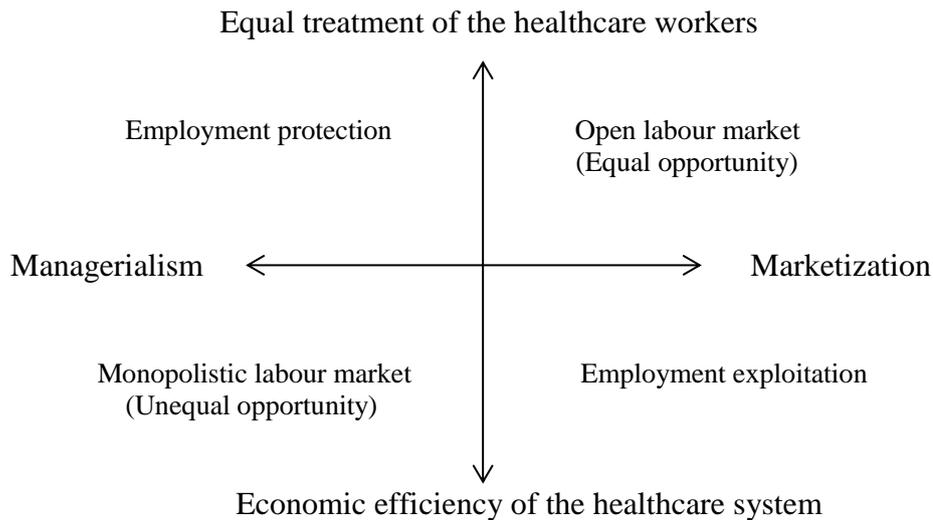


Figure 1: The matrix model of NPM effects on recruitment of migrant healthcare workers

Source:

- 1) Managerialism and marketization is from *The New Public Management Approach and Crisis States* (Larbi, 1999: 13)
- 2) Equal treatment of healthcare workers and Economic efficiency of the healthcare system is from 'Vitalizing' State Bureaux: Some Ethico-Political Consequences of Reinventing Government, in Du Gay, P. (ed.) *In praise of bureaucracy: Weber, Organisation, Ethics*. (Du Gay, 2000: 98-99)

2.2 Methods and data

Blank and Burau (2014) describe that comparative public policy is able to prove the similarities and differences of various issues related to healthcare. It would ultimately enhance policy choices and show various operational methods (Blank and Burau, 2014). This case study of Japan and Norway finds a similarity in the demographic transition to ageing societies, while it finds differences in regulatory frameworks of international healthcare workers recruitment between two countries. Learning their similarities and differences may offer insightful thoughts for possible future policy suggestions on the dynamics of international healthcare recruitment systems. Thus, this case study of Japan and Norway compares the international healthcare recruitment systems of both countries with available data on migrant health care workers from non-EEA countries.

Data used in this study are mainly from OECD, ILO, WHO, UDI, MHLW and JICWELS, which show: the demographic transition of ageing population, demand and supply of

healthcare workers, statistics on healthcare workers' working conditions, the ratification of ILO Conventions, National Reporting Instrument on WHO Global Code of Practice on the International Recruitment of Health Personnel, regulatory frameworks/policies in healthcare workers' recruitment and trend of healthcare sector reforms and their effects on regulatory framework for healthcare sector. The results of these data will be discussed later. Following are detailed descriptions of data used in this study.

2.2.1 Statistical data

Statistical data are mainly obtained from OECD. Stat. There is insufficient data on migrant healthcare workers as well as comparable data from the two countries. OECD (2014) recognises weaknesses in Norwegian statistical data on migrant workers' education overseas with their job data and registry of their residence permit records. The said report contains little data on migrant healthcare workers. Similarly, the data on healthcare migrant workers in Japan are extremely limited. The number of annual inflow and outflow of foreign nurses and care workers under the Economic Partnership Agreement and their success in the Japanese board examination are only available (MHLW, 2015). Hence, statistical data on migrant health care workers in both countries are very limited for this study. As a result, the extracted data for this study are mainly based on workers in other industries and local healthcare workers in Japan and Norway. From those data analyses on the status and condition of migrant healthcare workers are attempted. The working conditions of healthcare workers could possibly represent migrant healthcare workers. Thus, statistical data presented in this study could give important implications of effects on the working conditions of migrant healthcare workers. Extracted statistical data about Japan and Norway from OECD Statistics are: 1) LTC (Long-term care) workforce in formal sector (nurses); 2) Annual remuneration of nurses; 3) Average annual worked hours per worker; 4) Strictness of employment protection

(individual and collective dismissals - regular contracts) and 5) Quality of the working environment by education levels (OECD, 2016).

2.2.2 System comparison: Japan and Norway

WHO Global Code of Practice on the International Recruitment of Health Personnel

WHO Global Code of Practice on the International Recruitment of Health Personnel (Sixty-third World Health Assembly - WHA63.16, 2010), (hereafter the Code) is a voluntary code of practice for the recruitment of migrant healthcare workers, which consists of ten articles. In 2012 and 2015, National Reporting Instruments (NRI) of WHO (2012, 2015) were circulated among WHO member states in order to collect information about each country's situation related to the migrant healthcare workers. Questionnaires of NRI were about the basic rights of migrant health care workers, the regulatory framework on recruiting international healthcare workers, existence of statistical data on international healthcare workers, technical support to lower income countries and efforts to implement the Code in hosting countries (WHO, 2012, 2015). Reports of NRI of Japan and Norway were provided by the WHO office on the author's request for this study.

Regulatory framework for the international recruitment of healthcare workers

The format and data about 'Migration policy and recognition of foreign qualification for health professionals' (Dumont and Zurn, 2007: 223-224) are used for comparison of Japan's and Norway's systems on recruiting foreign-trained healthcare workers. It is noted that there are some changes in data of original source due to revision of regulations/law or fresh bilateral agreement in both countries since the publication of the report in 2007. Therefore, additional data sources of MHLW, OECD, UDI and WHO are used for supplementing data according to the change of events. The basic policy structure on migrant health workers' recruitment of both countries can be seen from Table 1.

Ratification of ILO Conventions

The trend of ratification of ILO Conventions related to migrant health workers could give some ideas about the level of legal protection. Moreover, the eagerness to change for better in terms of the basic right of migrant health workers in Japan and Norway can be seen. With reference of NORMLEX database: Information System of International Labour Standard at ILO website, the ratification of the fundamental Conventions (eight Conventions) and selected Conventions, including general migrant workers and health care workers (ILO, 2016a) are presented for analysis as Table 2. The situation of reporting on ratified Conventions by both countries (ILO, 2016b) is added for detailed analysis.

2.3 Limitations

There are three major limitations in this study. First, there are several studies generally related to migrant workers available. However, it is hard to find comparable data for *migrant healthcare workers*. There are a number of publications on issues and future perspectives on migration policy in Japan; however, there are very few studies on migrant healthcare workers. Similarly, Norwegian cases of migrant healthcare workers are presented briefly as a part of studies conducted by the EU and the OECD. Despite this critical limitation, this study tries to discuss similarities and differences in the international healthcare workers' recruitment systems of Japan and Norway, and the possible effects on working conditions of migrant healthcare workers.

Second, it is also related to the first limitation, as I am lacking in Norwegian proficiency, besides I have no access to studies written in Norwegian. Though I can access to the English translations of Norwegian laws and some studies and data presented in English. So, I focused on searching for studies and comparable data from EU and OECD sources. Thus, analysis of Norway might lack in detail.

Third, available data are sometimes not comparable because they are different in methods and variables. I use data mainly from OECD. Stat which depend on each country's database. Each country's data would defer in the content, which they want to collect for their policy analysis or new policy formation on the subject.

3. THE TREND OF LABOUR MIGRATION POLICY ON HEALTHCARE WORKERS: AN OVERVIEW

3.1 Global overview of labour migration

Industrialised countries share a general understanding of the correlation between ageing demography associated with a low total birth rate and a decrease of population. This situation could lead to the shortage of workforce. The current popular solution for countries with workforce shortage is recruiting workers from abroad.

There are a few points related to labour migration which needs to be clarified. First, according to Yorimitsu (2005), the labour force is composed of human being which possesses all natural human feelings and sentiments. Therefore, unlike other products such as agriculture products, the labour force, a product of human being can neither be stored nor can its quality be maintained by a third party (Yorimitsu, 2005).

Second, Endo (2009) explained that the migration of labour was not a new phenomenon; rather it has a long history. The trade of slavery existed even before B.C. during the era of the Greek and Roman empires. In recent history, African people were forced labour migration in the United States to be engaged in cotton cultivation (Endo, 2009). Korean people at the time of colonization of Korea (Fukuoka, 1996) as well as other Asians (Itai, 2009) were forced to migrate to Japan. Regardless of the mode of migration, either voluntary or forced, migration has a long history. The issues on migration have just become more global recently.

Third, Yorimitsu (2005) pointed out that the migrants needed to adopt new language to settle at a new destination and compromise their religious practice, customs, and the lifestyle which they originally belonged. Thus, when the benefit of cross border migration exceeds the cost of migration, people migrate (Yorimitsu, 2005).

Last, Endo (2009) stressed that the background and motivation of highly skilled migrant workers and unskilled migrant workers were different. The former could aim at better remuneration and status while the latter would manage to live their life at the lowest hierarchical status in destination countries (Endo, 2009). The main factor compelling unskilled workers to work at the place other than their original one, without their cultural or customary base was mainly due to their poverty (Endo, 2009).

3.2 The trend of policies/ legal framework on migrant healthcare workers

3.2.1 Reforms inspired by New Public Management

Brito, Galin and Novick (2001) pointed out that healthcare reforms in 1980's and 1990's paid less attention to human resources and their management, whereas healthcare services are highly labour-intensive. Only limited attention on human resources has gained the managerial concern for the improvement of efficiency and productivity (Brito, Galin and Novick, 2001). According to Larbi (1999), New Public Management reforms aiming at efficiency and cost cut through measures based on the market system were stimulated by economic and fiscal crises in developed countries. Later, those reforms were adopted in many developing countries' social sector policies (Larbi, 1999). The structural adjustment program targeted developing countries or countries in economic transition in order to reduce the expenditure on social sectors (Larbi, 1999). Glendinning (2013) provided an example of healthcare reform inspired by new public management, which took place in the United Kingdom known as "1993 Community Care Reform" (Glendinning, 2013: 183). It introduced successfully the market system into social care system where the public service was dominant (Glendinning, 2013). However, on the other hand, in the general process of health sector reforms, Brito, Galin and Novick (2001) added that the participation of employees did not occur despite high labour intensity in the sector. This shows that any reform would not be successful if high

authorities were reluctant to involve employees or citizens in the process of reforms (Brito, Galin and Novick, 2001).

3.2.2 Neoliberalism

New Public Management reform is inspired by neoliberal ideology. Neoliberalism is defined as:

Neoliberalism, ideology and policy model which emphasises the value of free market competition. (...) In particular, neoliberalism is often characterized in terms of its belief in sustained economic growth as the means to achieve human progress, its confidence in free markets as the most efficient allocation of resources, its emphasis on minimal state intervention in economic and social affairs, and its commitment to the freedom of trade and capital (Smith, 2016: first paragraph).

Itai (2009) argued that the economic theory of Chicago School of Neoliberalism considered that regulation in support of labour protection would result in a reduction of employment, and it would affect the vulnerable labourers negatively. Therefore, the best way of labour protection is to increase the demand for labour, which should be done by industries, but not by public administrations (Itai, 2009). In addition, Sawa, interviewed by Saitou (2009) added that economic globalisation was generally supported by multi-national industries as well as by conservative regimes; while, the globalisation of labour mobility was supported by the centre-left regime in the late 1990's Europe, which accelerated global migrant workers' mobility (Cited in Saitou, 2009: 162-163). According to Umemoto (2009), in the 1980s Neo-liberal policies flourished in developed countries such as the United States, the United Kingdom and Japan. This enabled the larger industries to seek for more profits and the middle size industries to seek for cheap labour to sustain their business (Umemoto, 2009). Thus, as mentioned above, fiscal crises, accelerated globalisation along with cross-border mobility of

services and workers and public sector reforms in the 1980s and 1990s were all correlated. The above situation led changes in the regulatory framework of healthcare worker recruitment; as a result, the working conditions dramatically changed. This promoted cheap labour with less protection. It was perhaps because the priority of reform was on more economic efficiency than quality maintenance. The details on regulatory framework on migrant healthcare workers are given in chapter 4 and 5.

3.3 The efforts to protect healthcare workers at international level

As discussed earlier, academics have raised concerns about the negative effects of poor working conditions for migrant workers, as well as deprivation of human resources of the source countries. Those negative impacts are identified as: 1) “a brain drain of highly skilled worker” from source countries (Bach, 2003: 1); 2) “the dislocation of migrant workers” (Bach, 2003: 1), defining the status of migrant workers as the undervalued members of society (Parreñas and Parreñas, 2015: 26); 3) the gender consequences of vulnerable group of workers as female workers are more exposed to physical and psychological abuse (International Organization for Migration, 2003); 4) “deskilling” (Bach, 2003: 17), the reduction in recognition of skill, which is considered lower in host countries than was the case in source countries (Asato, 2011a). This results in unfair treatment in salary and working conditions (Bach, 2003). Following are negative effects on migrant workers in other industries: 1) migrant workers’ engagement in “3K job – kitsui (demanding), kitanai (dirty), and kiken (dangerous)” in Japan (Kashiwazaki, 2002: Visa Overstayer); 2) “social dumping” in Norway (OECD, 2014: 89) which is defined by Bernaciak as “the strategy geared towards the lowering of social standards for the sake of enhanced competitiveness” (Bernaciak, 2012: 25); 3) “security deposit” practice (Yasuda, 2010) in Japan; trainees’ payment to local intermediary at the time of departure as guarantee, which will be returned to the trainees only on successful completion of training term (Yasuda, 2010: 40). In order to address the negative

consequences of international recruitment, many stakeholders have been involved in the improvement of the above-mentioned situation and practices. This is done through providing legal advice to affected migrant workers, besides, raising awareness for fair treatment of migrant workers. It may be mentioned that in 2007 and 2008 in Kumamoto, Japan, a local union started two court cases in support of Chinese trainees belonging to other industries, who were kept in inhuman working conditions (Gaikokujin Rōdōsha Mondai to Kore kara no Nihon Henshū Inikai, 2009). Initially, local labour unions provided them protection and lawyers formed the defence team for court proceeding against their employers and an intermediary (Gaikokujin Rōdōsha Mondai to Kore kara no Nihon Henshū Inikai, 2009). Having said this, in fact, the globalised recruitment practices may involve a number of stakeholders; enterprises, intermediaries, recruiting and receiving governments, labour unions and professional groups. Thus, all the stakeholders increasingly need to deal with the globalised labour issues. Moreover, international organisations as well as civil society could possibly provide the required leadership for setting up the international standard of practices for the international recruitment and advocacy for international communities. Some examples of the effort by international organisations are presented in the following section.

3.3.1 ILO Decent Work Indicator

Decent Work Indicator: Concepts and Definition (Castillo et al., 2012), the first version was published in 2012 based on the recommendation of the 2008 *ILO Declaration on Social Justice for a Fair Globalization*. Its philosophical base was “sustainable poverty reduction” (Castillo et al., 2012), and the indicator presents “a description of the statistical and legal framework indicators” (Castillo et al., 2012). The indicator promotes standardised comprehensive data collection in order to enable future studies on globalized workforce. Besides, it advocates all stakeholders about the importance of those data components to

acknowledge. This comprehensive indicator for promoting the decent work is indeed a welcome move.

3.3.2 WHO Global Code of Practice on the International Recruitment of Health Personnel

WHO Global Code of Practice on the International Recruitment of Health Personnel (hereafter ‘the Code’) was presented at the Sixty-third World Health Assembly (WHA) after adaptation of *The Kampala Declaration and Agenda for Global Action* (2008) (Sixty-third World Health Assembly - WHA63.16, 2010). Sixty-third World Health Assembly (2010) clarified that the Code was developed due to the concern shown by the member states towards the severe shortage of healthcare workers for which proper recruitment practices were to be followed. The inadequacies in the practice of international recruitment of healthcare workers could damage the health system and lessen the ability of countries to achieve development goals (Sixty-third World Health Assembly - WHA63.16, 2010). It consists of ten articles. Siyam *et al.* (2013) described that it was a form of soft law; therefore, implementation of the Code was kept as free choice of each member state. The Code has “flexible procedural mechanism” (Siyam *et al.*, 2013: 816) for implementation, and it is a “non-legal instrument” (Siyam *et al.*, 2013: 816). This voluntary instrument allows member states to implement the Code according to their capacity development for new policy formulation and adjustment of existing regulatory frameworks. The implementation of the Code would show how much each member state is determined to protect the interests of migrant healthcare workers and to provide source countries with technical support.

3.3.3 ISO 26000 Social Responsibility

International Organization for Standardization (ISO) is an independent and non-governmental organisation which consists of the 163 national standard bodies as members (ISO, 2016c). ISO 26000: 2010 provides guidance, but not a requirement, therefore certification will not be given (ISO, 2016b). According to Tamura (2011), developing countries initiated the

discussion of ISO 26000 in 2005 which initially suggested standardization of Corporate Social Responsibility. However, the ISO 26000: 2010 was agreed as an international standard of Social Responsibility with the idea of sharing the responsibility among corporations, municipalities, unions and Non-Governmental Organizations (Tamura, 2011). It contains seven core subjects:

- 1) Organisational governance; 2) Human rights; 3) Labour practice; 4) The environment;
- 5) Fair operating practice; 6) Consumer issue; and 7) Community involvement and development (ISO, 2014).

This ISO standard also is voluntary to implement, not binding, therefore, it has rather strong advocacy (ISO, 2016a).

3.4 Summary

The labour force has a special characteristic as a product of a human being which is strongly connected with the will of a human. It is neither storable, nor controllable by the other. Labour mobility has a long history either voluntary or forced. On voluntary migration, there are two types of purposes in migration; one is seeking for the better opportunity and the other is getting out of poverty.

In the 1980's and 1990's, fiscal crises triggered public sector reforms inspired by the neoliberal ideology which is called as New Public Management (NPM). The NPM has steered the management of public health sector in high-income countries towards private and market-based management. Changes in management philosophies and methodologies along with globalised mobility of labour have affected the health systems of their countries, and so have the working conditions of migrant healthcare workers.

Negative effects on the international recruitment of healthcare workers recognised by scholars are: deterioration of the health system in source countries and the exploitation of these workers in destination countries. However, there are efforts to improve general working conditions and recruitment practices for migrant workers including healthcare workers. This consists legal advice and action by lawyers and unions; establishment of indicators and guidelines for labour issues and good practices.

4. THE REGULATORY FRAMEWORK OF MIGRANT HEALTHCARE WORKERS IN JAPAN AND NORWAY

4.1 Japan

4.1.1 Migration Policy Overview

Castles, Haas and Miller (2008) explained that Japan's migration policy remained historically restrictive for labour migrants and immigrants. It was because the reason to maintain "ethnic homogeneity" in Japan (Castles, Haas and Miller, 2008). Japan had a long history of trade only with Chinese and Dutch till 1854, when United States persuaded Japan to open up sea ports (Office of the Historian, 2015). Moreover, Japan's geographic position as the islands at the east end of Eurasia continent could have limited access from other countries, except for close neighbouring countries.

The current regulatory framework on immigrant and migrant workers in Japan is *Immigration Control and Refugee Recognition Act* (1951) enacted in 1951 and later revised many times. It ensures that the procedures of the entry and exit of foreign nationals and refugees' acceptance in Japan will be dealt with fairly and in a right manner (*Japanese Law Translation: Immigration Control and Refugee Recognition Act (Cabinet Order No. 319 of 1951) 1951*). Immigration Bureau of Japan (2015) explains that under the Act, foreign nationals staying in Japan are categorised into 27 statuses of residence, in which 23 residency statuses are based on activities and 4 statuses are based on the status and identification. The later 4 statuses of residence do not have any limit over selection in the types of employment (Immigration Bureau of Japan, 2015; Suzuki, 2005). While, according to Li (2012), out of the 23 statuses of residence based on activities, 17 statuses are permitted to work according to their activities/specialities, and in addition, the other three statuses of residence; 'Student', 'Trainee', and 'Designated Activities' can engage in part-time work upon the approval of

‘Activities outside qualification’ (Li, 2012: 190). Thus, total 24 statuses of residence are permitted to work either full time or part time (Immigration Bureau of Japan, 2015; Li, 2012: 190). The Designated Activities apply to the nurse and care worker candidates through a program of the Economic Partnership Agreement (EPA) (MHLW, 2015) which will be discussed later.

Evolution of immigration policy in Japan

Akashi (2011) explained that the evolution of immigration policy in Japan could be seen in three phases of discussions on the acceptance of low-skilled migrant workers. The first phase started in the late 1980s when Japan was in an Economic Bubble (Akashi, 2011). Japanese manufacture industries faced a serious shortage of workers, resulting in bankruptcy due to unavailability of workers (Akashi, 2011). Furthermore, young Japanese’s tendency to avoid “3K job- kitanai (dirty), kitsui (demanding) and kiken (dangerous)” (Akashi, 2011) which were prevalent in industries such as agriculture, fishery, forestry and manufacturing, made the situation worse (Akashi, 2011). By Plaza Accord in 1985, Japanese yen rate was set higher against US dollar; Japan became a very attractive destination for foreign workers (Akashi, 2011). During this period, the inflow of illegal workers in Japan increased (Akashi, 2011)

In 1989, according to Suzuki (2005), the revision of *Immigration Control and Refugee Recognition Act* (1990 in force) was made on two grounds: 1) the revision of statuses of residence and its expansion and 2) the establishment of a criminal offence against any assistance for the illegal employment penalising employers (Suzuki, 2005). The revision was based on the 1998 cabinet decision on the enhancement of acceptance of high-skilled workers, but non-acceptance of low-skilled workers from abroad (Suzuki, 2005). Li (2012) added that despite this official stance, the revised act created a new residence of status “Long Term Resident” which permitted the third generation of Japanese descents and their spouse to engage in any work without limitation in the duration of stay. Many Japanese descents from

the South American countries came to Japan and engaged as low-skilled workers in 3K jobs (Li, 2012). In fact, the revised act intended to control the illegal migrants engaged in low-skilled work. But Yasuda (2010) argued that actually the act created a pathway for the entry of low-skilled workers by establishing a new status of residence, despite the official ban on accepting low-skilled migrant workers. In addition, trainees and technical interns' engagement in unskilled labour also increased (Akashi, 2011). Following the end of Economic Bubble in the early 1990s, Japanese economy turned into low growth and unemployment increased, as a result, the enthusiasm to accept the low-skilled migrant workers lost its strength (Suzuki, 2005).

In the late 1990s, the second phase of the discussion over the low-skilled migrant workers regained momentum (Akashi, 2011). Akashi (2011) put following two factors to explain this phenomenon. First, it was because chronically mismatched demand and supply of labour in certain occupations were not resolved. Secondly, the demographic transition towards ageing along with a decrease in productive age population became prominent (Akashi, 2011). Akashi (2011) explained that even though it was slow economic growth and high unemployment, some sectors suffered a serious shortage of workers. This situation revived the discussion about the acceptance of the low-skilled migrant workers (Akashi, 2011). Meanwhile, Japan adjusted the status of residence and its category related to short-term and low-skilled foreign workers for industries' satisfaction and convenience (Akashi, 2011). Akashi (2011) asserted that such protective policies have made some industries more dependent on those foreign workers.

After entering the 21st century, Japan's economy gradually improved and the number of foreign workers increased till the global recession followed by the bankruptcy of American financial firm, the Lehman Brothers in 2008 (Akashi, 2011). The third phase of discussions of

the acceptance of the low-skilled migrant workers came up due to concerns of the population decrease which induced the supportive argument for the acceptance of migrant workers (Akashi, 2011). In 2004, the Government of Japan started discussions with the Philippines and other countries regarding receiving trainees; nurses and certified care workers (Suzuki, 2005).

4.1.2 Economic Partnership Agreement (EPA) on nurse and certified care worker

Economic Partnership Agreement (hereafter EPA) is defined as:

EPA is a treaty which enhances cooperation in various fields such as the trade of goods and services, movement of people, protection of intellectual property right, investment and competition policy. It aims at close and strengthened bilateral or multilateral relationship (JICWELS, 2015: 1, translated by the author)

In April 2016, the status of residence of foreign candidates for the nurse and certified care worker in Japan are granted a status of residence “Designated Activities” under the EPA (Immigration Bureau of Japan, 2015; Ueno, 3/24/2015). According to Ministry of Health, Labour and Welfare (MHLW) (2015), countries exchanged the EPA with Japan are the Indonesia (2008), the Philippines (2009) and the Viet Nam (2014) (MHLW, 2015). Japan International Corporation of Welfare Services (JICWELS) (2015) is the only official intermediary organisation for the EPA programme. The EPA is a special case for receiving foreign trainees in the health sector because no statuses of residence exist for those EPA trainees (JICWELS, 2015). Furthermore, the main objective of bilateral EPA is to assist foreign candidates to obtain the Japanese qualification of either nurse or certified care worker while engaging them as trainees in healthcare institutes (MHLW, 2015).

Asato pointed out (2011a) that EPA was agreed without authentication of healthcare qualification of foreign candidate. Therefore, Japan receives qualified candidates, who intend to receive professional training and they engage in employment during their stay (Asato,

2011a). The duration of training is three years for the nurse and four years for certified care worker (MHLW, 2015). Asato (2011a) explains the procedure of the EPA programme as: the EPA nurse candidates, who are qualified nurses from originating countries, have a three-time chance to attempt for a Japanese board exam. Whereas, the qualification of the certified care worker has originally developed in Japan, in which all candidates require three years' relevant work experience in Japan for eligibility of the board exam (Asato, 2011a). Thus, the foreign care worker candidates have only one chance to attempt within four years' stay in Japan (Asato, 2011a). Furthermore, as both the examinations are conducted in Japanese, the candidates require a high level of Japanese proficiency (JICWELS, 2015). After obtaining a national qualification in Japan, they get an extension of status of residence and can engage in their professional work in Japan (MHLW, 2015). The objective of the Government of Japan is to maintain the standard of safety and quality of health care services; therefore, all foreign candidates must obtain the Japanese qualification (JICWELS, 2015).

It is important to note some points here about the weakness of the EPA programme. First, Asato (2011a) points out foreign nurse's deskilling and blank periods of experience during their training in Japan. Under the EPA program, nurse candidates should have two or three years' experience from their countries of origin in order to participate in the EPA programme (MHLW, 2015). However, they cannot engage in their profession as nurses till they successfully obtain the Japanese qualification (Asato, 2011a). Thus, during their stay in Japan as trainees, the blank period of their professional experience will arise. Similarly, candidates for certified care workers who were fresh graduate nurses in the country of origin, they will face the same problem as well (Asato, 2011a).

Second, the EPA programme includes both training and employment at the healthcare facilities but without any standard rules or regulations, which creates confusion on the part of

candidates and institutes. JICWELS (2015) only suggests that regulation at work would be arranged by each institute and submission of regular reporting on training status from the institutes.

Thirdly, there is the high financial burden to be borne by the institute for the training of candidates. The service charge and training cost of JICWELS, mediation costs of the intermediary in a source country and the tuition fee of the language course are to be covered by the training institute (JICWELS, 2015). The total estimated cost for one candidate in the first year is USD 7700 for the Indonesian and the Filipino candidate, and USD 5400 for the Vietnamese candidate (JICWELS, 2015).

4.1.3 Framework of receiving candidate as a nurse and care worker under the EPA

MHLW (2015: 1-2) provides the framework of accepting candidates under the EPA scheme, which is presented in two flow charts given below as Figure 2 and 3. Figure 2 presents the frameworks of acceptance from Indonesia, the Philippines, and Viet Nam before entry and at the time of arrival in Japan (MHLW, 2015). Indonesia and the Philippines have entered EPA earlier and their pre-departure processes are similar. Only one difference between these two countries is the years of required experience as a nurse which is two years for the Indonesians and three years for the Filipinos (MHLW, 2015). Indonesian and Filipino candidates get matching with Japanese health facilities then they get six month' Japanese language training and the language test before departure (MHLW, 2015). While, Vietnamese candidates get twelve months' Japanese language training and language test, then proceed for matching. Indonesian and Filipino candidates require getting basic language skills (MHLW, 2015). On the other hand, Vietnamese candidates require a higher level language skills before entry to Japan (MHLW, 2015).

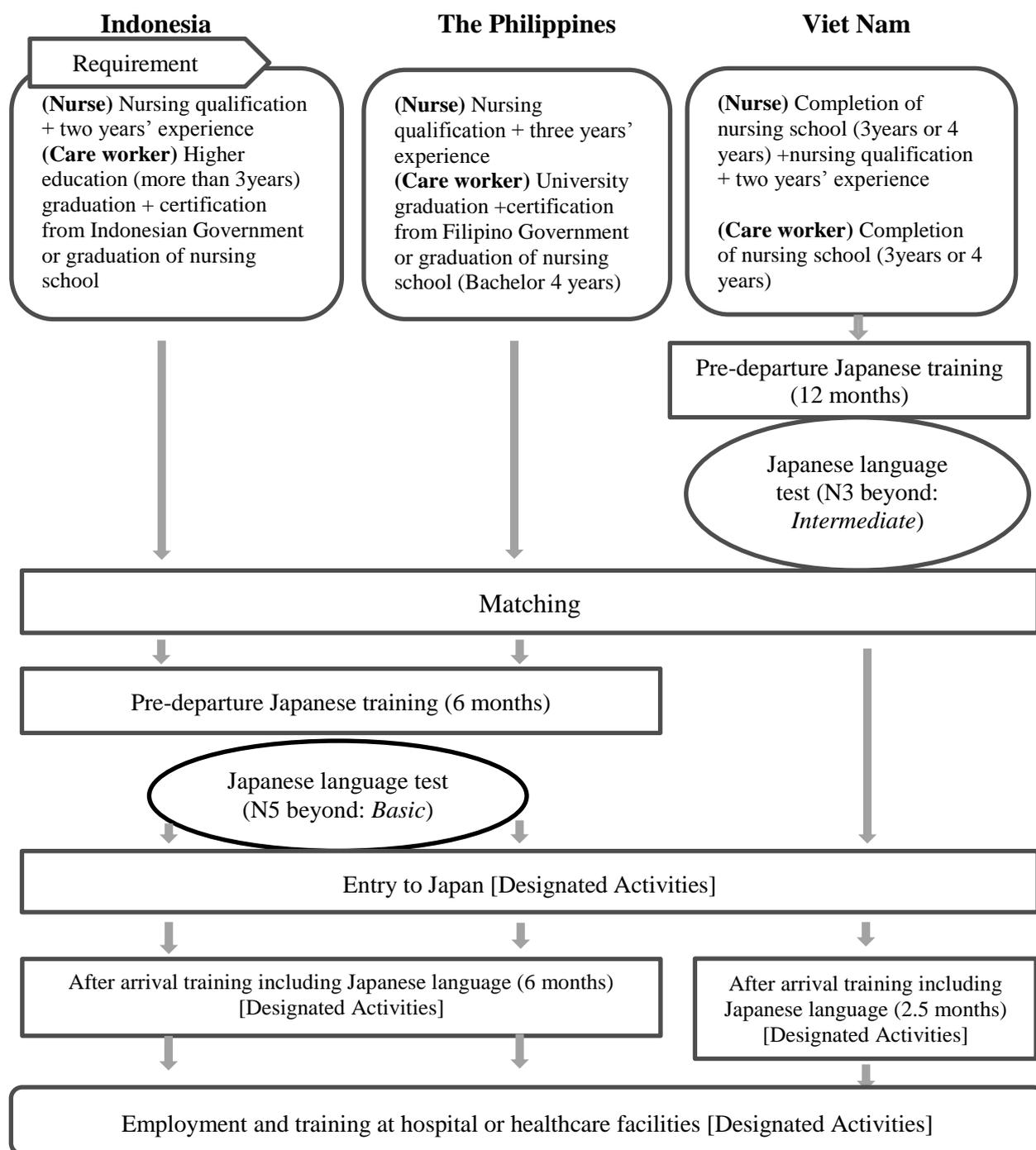


Figure 2: Framework of accepting candidates before entry and at the time of arrival

Note:

[] Indicates the status of residence.

Italics explain Japanese language-Proficiency Test grade N2 beyond holder is exempted from language training.

Source:

- 1) *Keizairenkei-kyoutei ni motozuku ukeire no wakugumi [The framework of acceptance of Economic Partnership Agreement]* (MHLW, 2015: 1) Translated by the author
- 2) Italics from *Japanese-Language Proficiency Test (JLPT). N1-N5: Summary of Linguistic Competence Required for Each Level* (The Japan Foundation/ Japan Educational Exchanges and Services, 2016)

Figure 3 shows how the EPA candidates after their arrival in Japan will engage in training and employment and prepare for their national board exams (MHLW, 2015: 2). Both candidates are granted a status of residence, “Designated activity”, nurse candidates for three years and care worker candidates four years (MHLW, 2015). During their stay in Japan, both candidates are expected to pass the exams, while engaging in work (MHLW, 2015). For the nurse candidate, there are three attempts to take the national exam, while the care worker candidate has only one attempt as they require three years’ experience to be eligible for the exam (MHLW, 2015). The success rate of the national exam by EPA candidates has remained low as 7.3% for the nurse, and 44.8% for the care worker candidates in 2014 (MHLW, 2015: 4). For non-Japanese to attempt professional exam in Japanese is not an easy task. Considering the difficulty in gaining Japanese qualification, the authority may grant one-year extension to unsuccessful candidates at the end of their stay (MHLW, 2015).

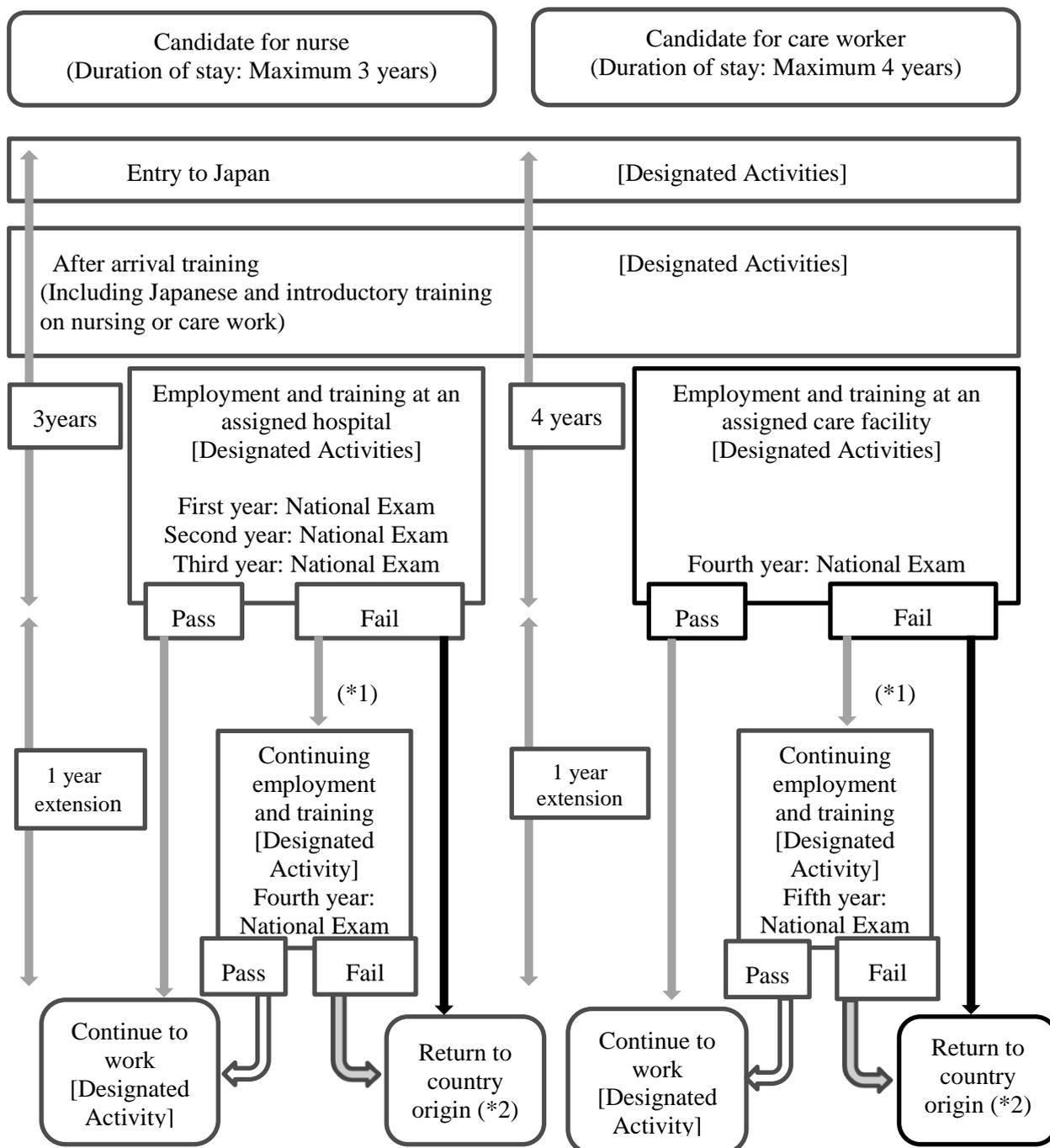


Figure 3: The framework of acceptance of candidate after arrival

Note:

(*1) If candidate fulfils basic requirement, one-year extension will be granted in case of failing exam

(*2) After returning to country origin, the candidate can re-enter with the status of entry ‘Short Stay’ and can try again for the exam.

[] indicates the status of residence

Source:

Keizairenkei-kyoutei ni motozuku ukeire no wakugumi [The framework of acceptance of Economic Partnership Agreement] (MHLW, 2015: 2) Translated by the author

4.1.4 Situation of the EPA candidate after obtaining a Japanese qualification

Matsukawa and Morimoto (2016) reported that 30% of EPA nurses and certified care workers who succeeded in national board exams, after some time they left from the EPA framework. After obtaining Japanese qualification, they won't receive any financial support for housing and study time as they used to have as candidates (Matsukawa and Morimoto, 2016). Furthermore, there is little increase in their salary as well as difficulty to take long-term leave (Matsukawa and Morimoto, 2016). More importantly, official support system is lacking to resolve their various issues both professional and personal lives (Matsukawa and Morimoto, 2016).

4.2 Norway

4.2.1 Migration Policy Overview

Norwegian migration policy is based on the ideology of egalitarianism (OECD, 2014; Papademetriou and O'Neil, 2004). Policy makers recognising limited resources such as 'human, technical, and capital' (Papademetriou and O'Neil, 2004) made following two principles of migration policy: 1) restrictive acceptance of immigrants and 2) equal treatment of immigrants having legal and practical opportunities (Papademetriou and O'Neil, 2004: 3-5).

The migration policy has evolved since Norway's entry to Nordic labour market in 1954 (Papademetriou and O'Neil, 2004). In 1956, by the revision of *Norwegian Foreign Law* (1927), Norway opened labour migration from other Nordic countries (OECD, 2014). Since then Norwegian migration policies have been influenced by socio-economic and political considerations of neighbouring countries (OECD, 2014; Papademetriou and O'Neil, 2004). Labour migrants in Norway gradually increased from other Nordic, European and non-European countries till 'temporary labour immigration stop' in 1975 (OECD, 2014: 66). It was mainly due to the economic downturn in other European countries affected by the oil crisis (OECD, 2014). However, OECD (2014) explains that the industries in short supply of

workforce were allowed to accept migrant workers on conditions as: 1) more than one year contract while limiting the number of the migrant worker per employer, 2) the Norwegian tariff agreement should be applied to the wage and condition of foreign worker and 3) the employer should arrange contract paper in the worker's own language and housing of the worker (OECD, 2014: 66-67). It may be noted that the Immigration Stop had served to accommodate more humanitarian migration, for example, asylum seekers and family unification (OECD, 2014).

In the 1980s and 1990s, Norway went through several migration policy changes (OECD, 2014). This entailed revising *Immigration Act* in 1988, establishment of the Norwegian Directorate of Immigration (UDI) for the purpose of centralising migration application process (OECD, 2014) and entering the European Economic Area (EEA) agreement to join the Single Market of the EU (Papademetriou and O'Neil, 2004). EEA agreement has made Norway the part of free movement of services and workers throughout EU/EEA states (EFTA Secretariat, 2016). Papademetriou and O'Neil (2004) claim that even though these changes still have not affected the above two principles of limited acceptance of migrants and equal opportunity of migrants in Norway.

4.2.2 Norway's EEA Agreement

The European Economic Area (EEA) is legislated by *EEA Agreement* in which all the EU Member States and the three EEA EFTA (European Free Trade Association) States (Iceland, Liechtenstein and Norway) have formed the Single Market since 1994 (EFTA Secretariat, 2016). EEA Agreement includes the four freedoms; free movement of goods, capital, services and persons, along with competition and state aid rules (EFTA Secretariat, 2016). While, the Agreement does not include the EU policies of common agriculture, fishery, trade, foreign and security policies, customs and monetary unions, justice and home affairs (EFTA Secretariat, 2016). Although Norway is not a member of the EU, but as a member state of the

EFTA which has entered the EEA Agreement, along with Iceland and Liechtenstein (except for Switzerland), Norway is a part of the internal market of the EU (EFTA Secretariat, 2016).

The free movement of persons and services gives citizens of all EEA countries the right 'to live, work, establish business and study in any of these countries' (EFTA Secretariat, 2016). Hence, Norwegians can freely access to labour markets within EU/EEA countries with the same equal rights and obligation of EU/EEA states, and so can all EU/EEA citizens (Papademetriou and O'Neil, 2004). Furthermore, in order to facilitate the free movement of persons to all nationals of EU/EEA states, the Agreement provides the rule with the recognition of professional qualifications and social security coordination to the citizens of all member states (EFTA Secretariat, 2016). However, this study focuses on the international recruitment of healthcare workers in Norway from non-EEA countries which are not part of the EEA Agreement.

4.2.3 Application process of healthcare workers' authorisation as skilled workers

Public Service International (2015) introduces that the Norwegian Registration Authority for Health Personnel (SAK) is a competent authority for authorisation of health workers. At the website of SAK/ Helsedirektoratet (2016), the applicant needs to create an account in order to start the process of authorisation. With handling fee, the applicant must submit the required documents for authorisation, which takes about six weeks for Nordic citizen, four months for the other EU/EEA citizen, and six months for non-EEA citizen (Helsedirektoratet, 2016). The pre-departure guide for Filipino and Indian nurses suggests an early application for the authorisation to SAK because there are a number of processes taking longer time for non-EEA citizen (Public Service International, 2015).

4.2.4 Legal status of skilled worker from non-EEA countries

Immigration Act (2008) regulates the entry and stay of foreign nationals facilitating their legal movement and protection in Norway, according to the regulatory framework on immigration

and international responsibilities (*Act of 15 May 2008 on the entry of foreign nationals into The Kingdom of Norway and their stay in the realm (Immigration Act) (Unofficial English Translation)* 2008). OECD (2014) reports that a Nordic citizen has no access barrier to residence and labour market within the Nordic cooperation. In addition, other EEA citizens have also free access to labour market with the obligation of registration after arrival in Norway (OECD, 2014). While skilled workers of non-EEA countries are subject to the application of temporary work permit of up to three years, which is renewable and permitted to change employment, but in the same occupation (OECD, 2014). For less skilled workers and seasonal workers, six months permit will be granted (OECD, 2014). Furthermore, the skilled workers and their families are eligible for the permanent residence after a continuous three years' stay in Norway as well as completion of language and civic course (OECD, 2014).

UDI (2016) clarifies the rights and the obligations of skilled workers' permit applications. The skilled workers are eligible to apply for a permanent residence permit after three years' stay in Norway. The applicant needs to apply for a new residence permit at the time of changing the occupation if it links with a certain employer (UDI, 2016). While, if the residence permit does not link with a certain employer, the applicant can change employer in the same occupation (UDI, 2016). Furthermore, the temporarily laid-off workers are allowed to stay in Norway till the expiry of a residence permit without notification to the police and the UDI (UDI, 2016). Whereas the dismissed worker may stay six months with valid residence permit for searching a new job, by notifying the authority within seven days after losing a job (UDI, 2016). The temporarily laid-off worker is eligible to claim an unemployment benefit during the layoff period (NAV, 2016a). The dismissed worker is also eligible for the benefit, but must register as a job seeker at NAV and with regular reporting about employment status (NAV, 2016b).

Following are some examples of current legal protections for the workers in Norway. *Working Environment Act* (2005) regulates the obligation of the employer and the status and rights of the employee, such as the requirement for recruitment, employment contract and termination, the working environment and employment protection (*Act relating to working environment, working hours and employment protection, etc. (Working Environment Act) 2005*). It applies to all employees, including director level position holders and employees at a foreign firm operating in Norway, except for government employees and self-employed (Hveding and Johansen, 2016). *The Health Personnel Act* (1999) states the rights and obligations of all health care workers and healthcare facilities. It also states the conditions on specialist authorisation, licence, and certification as well as Norwegian boards of health personnel and pharmacy (*Act of 2 July 1999 No. 64 relating to Health Personnel etc. (The Health Personnel Act) 1999*). During recent years, the rights of the temporary agency workers are strengthened through Norway's implementation of the Directive on temporary agency work (2008) in 2013 (Hveding and Johansen, 2016). The Directive advocates the working conditions of temporary workers, which is based on the fundamental rights of every worker in the Charter of Fundamental Rights of the European Union (*Directive 2008/104/EC of The European Parliament and of the Council of 19 November 2008 on temporary agency work 2008*). According to Steen (2015), *Working Environment Act* (2005) was revised in 2015. Amendment of the Act would affect short-term employment, duty hours, an extension of the age limit, increased penalties and weakened the power of unions for collective action (Steen, 2015).

4.3 Similarities and differences between the migration system of Japan and Norway

4.3.1 Similarities

- The importance of the principle of equal treatment is recognised by both countries.

- Restrictive admission of labour migrants and immigrants
- Preference to high-skilled workers

4.3.2 Differences

- Preference Policy in accepting labour migrants: Norway gives preference to Nordic citizen and secondly to the other EEA citizen. Medical qualification of the Nordic citizen is authorised within six weeks and four months for the other EEA citizen. Nordic citizen has free access to both residence and labour market with no obligation of registration, while the other EEA citizens have free access but require the registration. Japan gives the preference to Japanese descent and spouse of the Japanese/Permanent resident.
- Law enforcement: Norwegian laws have stronger enforcement while the Japanese law enforcement is weak because of simple administrative guidance, rather than the enforcement based on the legal statement of law
- Authentication of healthcare qualification: Japan does not accept foreign qualifications, while Norway accepts foreign qualification.
- Agreement for labour migration: Japan has a bilateral agreement of nursing assistant and care worker in the form of EPA with non-EEA countries, while Norway has no bilateral agreement with non-EEA countries. However, Norway has EEA agreement with EU/EEA for free movement of goods, services, capital and people; and also is part of the Nordic cooperation which allows Nordic citizen free movement and participation in labour within the Nordic countries.

The detailed comparison is given in chapter 5.

5. COMPARISON AND ANALYSIS

5.1 WHO Global Code of Practice on the International Recruitment of Health Personnel

WHO Global Code of Practice on the International Recruitment of Health Personnel (the Code) aims at establishing a unified framework for healthcare migration and health system strengthening through the promotion of discussion and collaboration (Siyam *et al.*, 2013). The Code entails great flexibility and adaptability for member states because it is kept as a voluntary instrument (Siyam *et al.*, 2013). Since its establishment in 2010, WHO has conducted monitoring survey twice (in 2012 and 2015), which is called National Reporting Instrument (WHO, 2012, 2015). WHO office has provided the result of surveys of Japan and Norway for this study on the author's request.

5.1.1 Results of National Reporting Instrument (NRI) in 2012

National Reporting Instrument (NRI) in 2012 was the first monitoring survey by WHO after the establishment of the Code (WHO, 2012). Based on the result of NRI from Japan and Norway, some important findings are presented below:

1. Both countries responded positively showing equally qualified and experienced migrant health workers having the same legal rights and responsibilities as for locally trained health workers. Despite the same response by both countries, mechanism ensuring the above differs between Japan and Norway. Japan identifies that foreign health workers are given same professional education, qualification and career progression as well as same protection through Labour Standard Act for the locally trained health workers. Norway identifies that the migrant health workers are provided information about the benefits and risk attached to employment, equal labour conditions, and the same opportunities of professional education, qualification and career progression. Moreover, Norway

encourages the Code advocacy amongst international recruitment agencies (WHO, 2012: Q1, 2).

2. Norway has a research institute, which conducts research on health worker migration, namely, Work Research Institute (Arbeidsforskningsinstituttet/AFI) housed in Oslo and Akershus University College of Applied Sciences (HIOA, 2016). Japan has neither a research institute nor a programme to conduct the research, particularly on health worker migration (WHO, 2012: Q6, 7; WHO, 2015: Q13).
3. For implementation of the Code, Norway has taken steps, such as information sharing with all relevant stakeholders about issues relating to recruitment of migrant healthcare workers and their involvement in decision-making process on the subject. Moreover, Norway maintains the record of all authorized recruiters and encourages good practices on recruitment. While Japan extends the reason for not implementing the Code on the pretext that Japan does not currently recruit healthcare workers from overseas (WHO, 2012: Q8, 9).
4. Norway identifies the main constraints on the implementation of the Code. The constraints are a high pull factor of health workers to Norway from low and middle income countries, unsustainability of health workforce capacity due to the shortage of local healthcare workers in the future and insufficient domestic health worker's education where nearly half of medical doctors are trained abroad. It may be noted that how the above have become constraints is not stated in the NRI relating to Norway. Keeping in view, possible solutions as mentioned in the NRI for Norway, this author considers the following factors for constraints. Firstly, the better opportunities offered by Norway attract foreign health workers directly and also hiring through recruiters from low and middle income countries. Secondly, Norway is yet to increase the healthcare workforce and attain demographic stability, as well as focus on public health prevention strategies.

Third, insufficient domestic educational capacities, which encourage medical student to obtain qualification abroad. Japan does not present any constraints on the pretext that it has not implemented the Code (WHO, 2012: Q10).

5. Norway maintains statistical records of health workers whose first qualification is from abroad while Japan does not maintain any record in this behalf (WHO, 2012: Q13).
6. Norway has the regulating and authorising body which maintains the record of recruiting agencies hiring international health workers. On the other hand, Japan does not have any regulating body for the purpose (WHO, 2012: Q14).

5.1.2 Results of National Reporting Instrument (NRI) in 2015

National Reporting Instrument (NRI) in 2015 is the second survey after 2012. It consists of 24 questions as compared to 15 questions given in 2012 (WHO, 2015).

1. According to the survey of 2015, Q1) which is about the same legal rights and responsibilities are granted to equally qualified and experienced migrant health workers with local health workers. Norway responds positively, while Japan responds negatively. It may be noted that in the 2012 survey both countries responded positively (WHO, 2012: Q1; WHO, 2015: Q1).
2. About any mechanism which ensures fair recruitment and employment practice, Norway responds three following mechanisms: 1) implementation of *Working Environment Act* (2005) for all employers and employees without discrimination; 2) dissemination of the Code among all stakeholders after translating it into Norwegian language; and 3) organising a conference for exchange of views about the implementation of the Code. On the other hand, Japan does not have any mechanism to ensure fair recruitment practice of overseas healthcare workers (WHO, 2015: Q3).
3. For accommodating the need of developing countries and countries with the economic transition, Norway provides those countries with opportunity of training, collaboration of

healthcare organisations, sharing of retention strategies and education programs. While Japan does not have any arrangement in this behalf (WHO, 2015: Q7, 8).

4. For meeting the needs of locally trained health workers, Norway takes measures through education, retention and sustaining of the healthcare workers appropriately. While Japan, strangely enough responded that it has no measures at all for domestically trained healthcare workers (WHO, 2015: Q9, 10).
5. Both countries take measures to address the issue of geographical mal-distribution of health workers and to support their retention in areas where the health workers are in shortage. Norway's measures are: implementation of the quota system annually to allocate new positions of medical doctors for health facilities along with the introduction of their registry, national retention programme with economic and professional incentive and the decentralisation of health education and training as well as the health service. Japan's measures are: decentralisation of health facilities of Community Health Care Support Center and medical education and dispatching medical doctors to the healthcare facilities in underserved areas. But those are lacking in incentivized mechanisms for the retention of medical care professionals in underserved areas (WHO, 2015: Q11, 12).
6. Norway has established regulating body for authorisation of international recruited health workers as well as maintenance of their statistical records. While Japan has no such arrangement in this behalf (WHO, 2015: Q17).
7. Norway has implemented the Code and has identified other constraints in its implementation in addition to those identified in a previous survey. Newly informed constraints identified in the 2015 survey are lacking in specific regulation of recruitment agencies and information on migration patterns. Japan has not implemented the Code, thus none of the constraints have been identified (WHO, 2015: Q19, 21).

8. Norway provides assistance to member states and other stakeholders for their implementation of the Code. While Japan does not provide any assistance to any stakeholders (WHO, 2015: Q22).

5.1.3 Main Findings from two surveys of National Reporting Instrument (NRI)

At the time of the first survey conducted in 2012, both countries were conscious about better image of their countries on account of the international recruitment of health workers. At the time of the second survey in 2015, member states were asked for detailed information to assess their country situation on implementation of the Code as well as their efforts to address the issues of international recruitment of health workers.

Secondly, Norway has implemented the Code and has started to make efforts to meet the standards advocated under the Code. On the other hand, Japan has not implemented the Code on the pretext that they are not recruiting international health workers.

Lastly, it appears that Norway has shown more eagerness to adopt the international standard related to the recruitment, employment and retention of migrant health workers which is advocated by the Code. On the other hand, Japan has not shown any interest to attend to the required inquiries given in the Code.

5.2 Regulatory framework for the international recruitment of healthcare workers: Japan and Norway

Following is the comparison of the regulatory framework for the international recruitment of foreign-trained health workers in Japan and Norway. The data are mainly based on the table titled 'Migration Policies and Recognition of Foreign Qualification for Health Professionals' given in *International Migration Outlook* (Dumont and Zurn, 2007:223-224). This particular report was published in 2007, and contained a comprehensive comparative table which has not been included in subsequent reports of the International Migration Outlook. Therefore, the

format has been used for better understanding of the similarities and differences in international recruitment of healthcare workers for both countries. However, data obtained from different sources have also been incorporated in Table 1 which shows the changes happened in subsequent years. In this regard, newly incorporated information are under the headings: 1) Temporary migration (Norway), 2) Temporary migration (Japan), 3) Bilateral agreements relevant to health professionals in underserved areas or particular regions (Japan), 4) Code of conduct for the international recruitment of health professionals (Norway) and 5) Competent authorities for registration/certification or other relevant links (Norway) (Dumont and Zurn, 2007). The source and year of change are accordingly shown in the Table 1. Review of the Table 1 reveals following:

1) Japan does not grant the permanent residence for healthcare workers, while Norway grants it after three years' temporary residence permit (Dumont and Zurn, 2007: 223-224).

2) Japan recruits candidates of nurses and certified care workers through bilateral agreements (Dumont and Zurn, 2007: 223), while Norway does not have a bilateral agreement on healthcare workers recruitment with non-EEA countries (Dumont and Zurn, 2007: 224). However, Norway is part of the EEA agreement with EU/EEA for free movement of goods, services, peoples, and capital (EFTA Secretariat, 2016) as well as the Nordic cooperation (OECD, 2014).

3) In order to work as a health worker in Japan, the health worker needs to have Japanese qualification (Dumont and Zurn, 2007: 223). Norway recognises foreign education, especially from Switzerland and the EEA countries (Dumont and Zurn, 2007: 224).

4) No code of conduct for the recruitment of health professionals has been implemented in Japan (Dumont and Zurn, 2007; WHO, 2015), but the WHO Global Code on the International Recruitment of Health Personnel has been implemented in Norway (WHO, 2012).

Table 1: Migration Policies and Recognition of Foreign Qualification for Health Professionals: Japan and Norway

		Japan	Norway	
Main characteristics of migration policy and specification for health professionals	Permanent migration	Permanent migration programmes relevant for health professionals	No	Permanent residence permit (after 3 years with temporary permit)
		Specific conditions for health professionals (e.g. point system)	No	No
	Temporary migration	Temporary migration programmes related to health professionals #Y: Maximum duration, R: Renewable, LMT: Labour market test	"Medical Services" status of residence 1-3Y.R. (maximum 4 years for midwives and 7 years for registered nurses)	Skilled worker/ specialist (SWS) 1 Y. R. Job seeker visa (generally 3 months) (Dumont and Zurn, 2007), Jobseeker visa was abolished in 2013 (OECD, 2014), however, the job seeker visa are granted to skilled worker, fresh graduate and researcher (UDI, 2016).
		Quota	No, except within the Economic Partnership Agreement on nurse and certified care workers (Japan-Indonesia, Japan-Philippines, and Japan-Viet Nam) Quota: nurse is 200 per year and certified care worker is 300 per year for each country (MHLW, 2015)	Yes, for skilled worker specialists, but if the quota is full, it is still possible to grant a permit but under stricter conditions (labour market test)
	Shortage occupation list, specific mention of health professionals	No	No	
	Specific programmes for health professionals in underserved areas of particular regions	For doctors, previous limitations on workplace to remote areas, where Japanese doctors cannot be recruited, have been lifted (they still apply to dentists for instance).	No	
	Bilateral agreements relevant for health professionals in underserved areas or particular regions	The Economic Partnership Agreements: 1) Japan-Indonesia, 2) Japan-the Philippines, and 3) Japan-Vietnam. Nurse with 3 years' experience (Indonesia and the Philippines), or 2 years (Viet Nam) and certified care worker with the graduation of nursing are required (MHLW, 2015)	No, except with the EU and the Agreement on a Common Nordic Labour Market.	

		Japan	Norway
Recognition of foreign qualifications	Conditions on citizenship	No	No
	Language proficiency test	Yes	Yes, course and examination for doctors with a first language other than Norwegian, Swedish or Danish
	Professional examination	Need to obtain Japanese legal qualification	For EEA and Swiss nationals (and non-EEA in some cases), qualifications from Switzerland or EEA are recognised under the EU Directive. The Norwegian Registration Authority for Health Personnel gives the authorisation and licenses. Authorisation is granted to applicants who have completed a residency. The license is a permit to practice as a medical practitioner, but on certain conditions (restricted in time, locality, etc., and may only follow an assessment). If qualification is not equivalent it is possible to take bridging courses. When the foreign qualification has been approved, the applicant start residency. Prior work experience cannot be subtracted from the length of the residency period.
	Probation period Training programmes	No	
International recruitment agencies operating for health professionals are contracted or regulated		No	No
Foreign medical students can change status after completing their studies to obtain a work permit		Yes, but overseas students must obtain a "Medical Services" status of residence under general regulation	Possible, foreign students with a job offer as a health professional after completion of their education may be granted a work permit for up to 1 year. Norway offers scholarship grants (1100) to students from developing countries = return or repay.
Code of conduct for the international recruitment of health professionals		No	No. (Dumont and Zurn, 2007), Yes. Norway implemented the Code of WHO (WHO, 2012)
Competent authorities for registration/certification or other relevant links			www.safh.no (Dumont and Zurn, 2007), currently available at www.helsedirektoratet.no (Helsedirektoratet, 2016) and www.udi.no

Source:

- 1) 'PART III Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration', *International Migration Outlook 2007* (Dumont and Zurn, 2007: 223-224)
- 2) *Keizairenkei-kyoutei ni motozuku ukeire no wakugumi [The framework of acceptance of Economic Partnership Agreement]*(MHLW, 2015: 1)
- 3) *Recruiting immigrant workers: Norway 2014* (OECD, 2014: 100)
- 4) *Want to apply: Skilled workers* (UDI, 2016)
- 5) *WHO Global Code of Practice on the International Recruitment of Health Personnel: National Reporting Instrument* (WHO, 2012)
- 6) *Authorisation and License for Health Personnel* (Helsedirektoratet, 2016)

5.3 Ratification of ILO Conventions

International Labour Organization Conventions ratified by Japan and Norway would give a valuable insight on each country's eagerness and efforts for the promotion of better working conditions. In this section data from NORMLEX by ILO are used for references (ILO, 2016a, 2016b). Table 2 shows that the ratification of selected ILO Conventions related to migrant health workers along with their due comments and the total number of ratifications by Japan and Norway.

Japan ratified six Conventions out of eight fundamental Conventions. Currently, Japan has not ratified *C105-Abolition of Forced Labour Convention* (1957) and *C111-Discrimination (Employment and Occupation) Convention* (1958) of the fundamental Conventions (ILO, 2016a). On the other hand, Norway has ratified all the fundamental Conventions (ILO, 2016a).

The ratification of selected Conventions related to health care, migration and labour protection highlights labour issues. In this regard, Japan and Norway have resolved to implement those Conventions in their national regulatory frameworks. Japan does not ratify any of five selected Conventions relevant to migrant workers and health workers (ILO, 2016a). On the other hand, Norway has ratified all five Conventions (ILO, 2016a).

Moreover, the total numbers of ILO Convention ratification by Japan are 49 Conventions, of which 38 are in force (ILO, 2016a). While, Norway's total ratifications are 109 Conventions

and 1 Protocol, of which 74 are in force. The total number of Japan's ratifications are about half the number of Norway's ratifications (ILO, 2016a).

In the light of foregoing, the situation on ratification of the ILO Conventions by both countries shows that: 1) Japan lacks in political will to take up the national regulatory framework relevant to migrant workers to the international standard; 2) Norway has adopted more international standards through ratification of ILO Conventions in order to address the various labour issues; 3) Japan lacks in administrative capacities to work out the implementation of international standards. It is in light of the fact that the number of pending comments on six ratified fundamental Conventions by Japan are six reports (ILO, 2016b). On the other hand, Norway pends four reports on eight fundamental Conventions (ILO, 2016b). It should be noted that Japan's total ratification are about half of Norway, still Japan has more pending comments; 4) time lag on the ratification of Conventions between two governments may have created a gap in the development of national regulatory framework between two countries. For example, Japan ratified the ratification of *C138- minimum Age Convention* (1973) after twenty years of the ratification by Norway (see Table 2). Thus, the implementation of minimum age of Japanese regulations has been much delayed than Norway's progress on the subject.

Table 2: ILO Conventions Ratification and Due Comments by Japan and Norway

Fundamental Conventions (8)	Japan		Norway	
	Ratification	Pending comments	Ratification	Pending comments
C087 - Freedom of Association and Protection of the Right to Organize Convention, 1948 (No. 87)	1965	Observation 2014	1949	
C098 - Right to Organize and Collective Bargaining Convention, 1949 (No. 98)	1953	Observation 2014	1955	
C029 - Forced Labour Convention, 1930 (No. 29)	1932	Observation 2015	1932	
C105 - Abolition of Forced Labour Convention, 1957 (No. 105)			1958	
C100 - Equal Remuneration Convention, 1951 (No. 100)	1967	Observation 2014 Direct request 2014	1959	Observation 2013 Direct request 2013
C111 - Discrimination (Employment and Occupation) Convention, 1958 (No. 111)			1959	Direct request 2013
C138 - Minimum Age Convention, 1973 (No. 138)	2000		1980	
C182 - Worst Forms of Child Labour Convention, 1999 (No. 182)	2001	Acknowledgement 2015	2000	Acknowledgement 2015
Selected Conventions related to healthcare and migrant workers	Japan		Norway	
	Ratification	Pending comments	Ratification	Pending comments
C097 - Migration for Employment Convention (Revised), 1949 (No. 97)			1955	Direct Request 2013
C118 - Equality of Treatment (Social Security) Convention, 1962 (No. 118)			1963	
C143 - Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143)			1979	Direct Request 2013
C149 - Nursing Personnel Convention, 1977 (No. 149)			1989	
C168 - Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168)			1990	
Total ratifications of ILO Conventions	Out of the 49 Conventions ratified by Japan, of which 38 are in force		Out of the 109 Conventions and 1 Protocol ratified by Norway, of which 74 are in force	

Source:

ILO-NORMLEX Information System on International Labour Standards;

1) Ratifications by country (ILO, 2016a)

2) Regular reporting: ratified conventions (Art.22/35) (ILO, 2016b)

(Data extracted on 30/3/2016)

5.4 Statistical data related to workers of Japan and Norway

The data are extracted from OECD. Stat related to general workers, including healthcare workers in Japan and Norway (OECD, 2016). These data are not related specifically to migrant healthcare workers. However, data related to general healthcare workers in both countries may give precious insights for analysis of the working conditions and legal protection of migrant healthcare workers.

5.4.1 Working conditions of nurses in Japan and Norway

In this section, two figures are presented for the comparison of working conditions of nurses in Japan and Norway.

Availability of LTC workforce for the aged population

Figure 4 shows two sets of data on long-term care workforce (nurses) in the formal sector (the care workers are employed either in public or private sector, excluding the informal care worker who are not employed officially) in Japan and Norway from 2004 till 2013. Column graphs show the number of nurses who are engaged in the long-term care in the formal sector. The percentages of those nurses for total population beyond 65 years old are presented by line graphs. From this, the availability of nurses in the LTC sector in both countries can be seen.

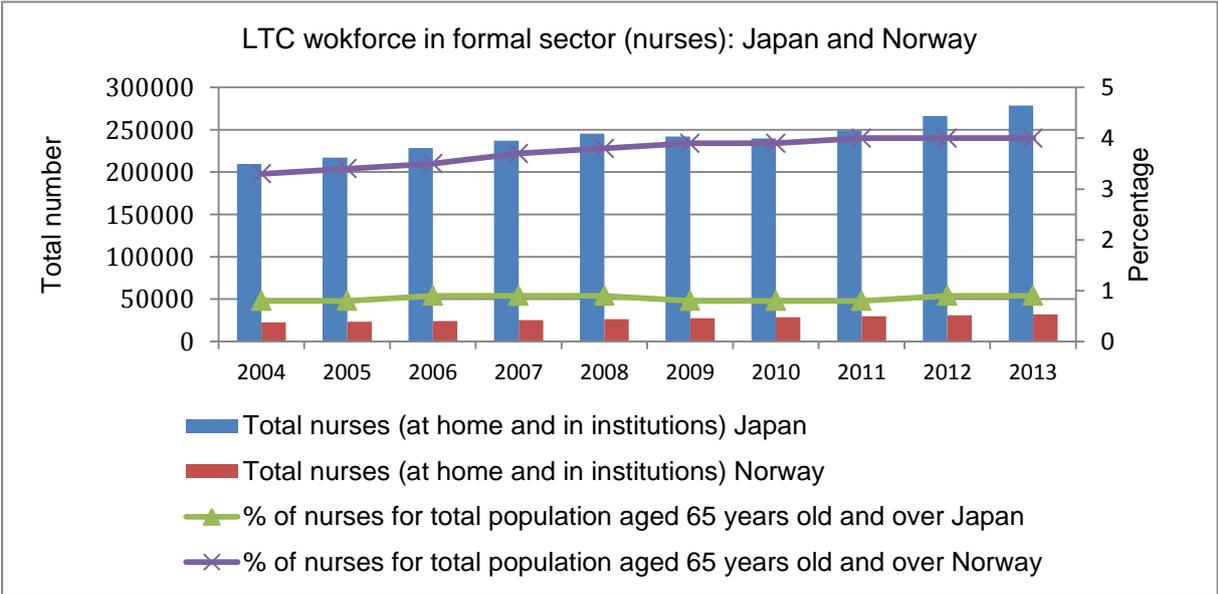


Figure 4: LTC workforce in formal sector (nurses): Japan and Norway

Source:

OECD. Stat; Health, Long-Term Care Resources and Utilisation (OECD, 2016)

Available at: <http://stats.oecd.org/index.aspx>

(Data extracted on 19/02/2016)

By analysing situation from the year 2004 to 2013, it appears that the number of nurses increased from 209,491 to 278,673 in Japan and from 22,496 to 31,911 in Norway, showing an increase of 33% and 42%, respectively (OECD, 2016). Although there are a large number of nurses in Japan, but only 1% is for the population beyond 65 years old. While in Norway, 4% are for the population of beyond 65 years old in 2013 (OECD, 2016).

Annual remuneration of nurses

Figure 5 shows an annual income of nurse in Japan and Norway. Data are presented in US dollars and US dollar PPP (Purchasing Power Parity) in 2008, 2010, and 2012 (Japanese data are available only in even years). The purpose of showing this comparison is the marked difference in remuneration for nurses in Japan and Norway, which is US dollars 56,636 (43,191 PPP) and 83,300 (54,429 PPP) respectively (OECD, 2016).

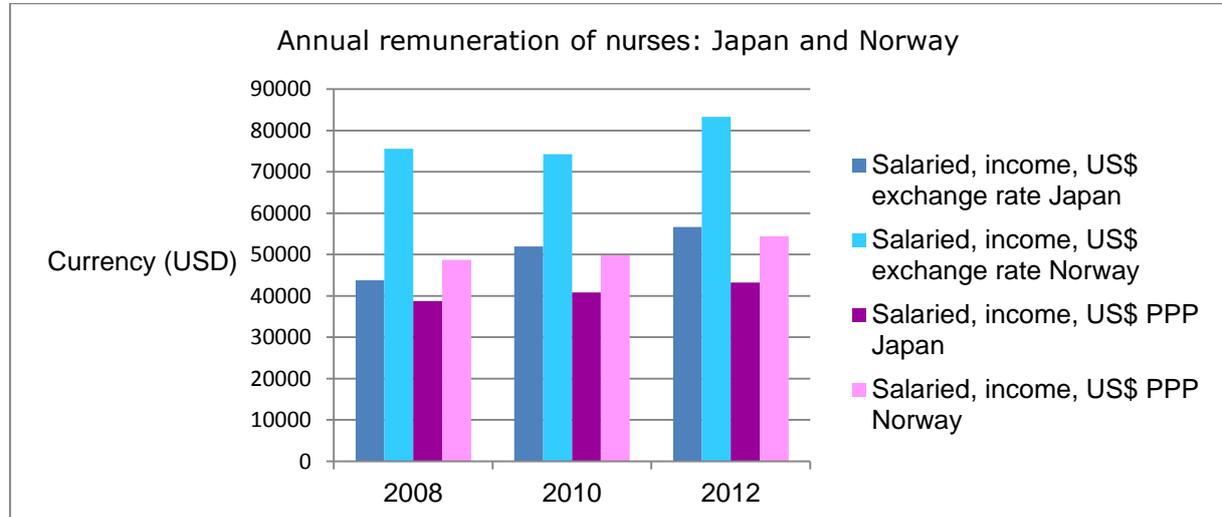


Figure 5: Annual remuneration of nurses: Japan and Norway

Source:

OECD. Stat; Health, Health Care Resources (OECD, 2016)

Available at: <http://stats.oecd.org/index.aspx>

(Data extracted on 19/02/2016)

According to the Economic Times, PPP is used to compare with the income level of each country (The Economic Times, 2016). It is pertinent to mention here that the annual income

in US dollar PPP still shows the low-level of income for Japanese nurses compared to Norwegian nurses, showing the gap of US dollar 11,000 in 2012 (OECD, 2016).

The above state of lower remuneration of nurses in Japan could discourage the new entry and retention. While, in Norway the demand and supply of nursing and caregiving are balanced according to an OECD report in 2014; however by 2029 the demand for those healthcare workers will outnumber the supply (OECD, 2014). Large scale increment of Norwegian nurses in 2012 could have been under serious consideration of the projection of increasing demand of healthcare workers. The increment in salary of the Norwegian nurse may reflect the intention of Norway to increase the number of healthcare workers in a great way. The increase in the new entrants and their retention of healthcare profession locally would be a very important healthcare policy initiative.

5.4.2 General working conditions and labour protection in Japan and Norway

In this section, three figures and a table are presented to observe the general working conditions and labour protection in Japan and Norway. As mentioned above, comparable data on working conditions are hard to find, both related to healthcare professionals and migrant healthcare workers.

Annual worked hours

Figure 6 shows average annual worked hours of Japanese and Norwegian workers for the last fifteen years from 2000 to 2014. Data on healthcare professional worked hours are not available in OECD statistics. Therefore, the general worker's worked hours are presented for analysis to see the trend.

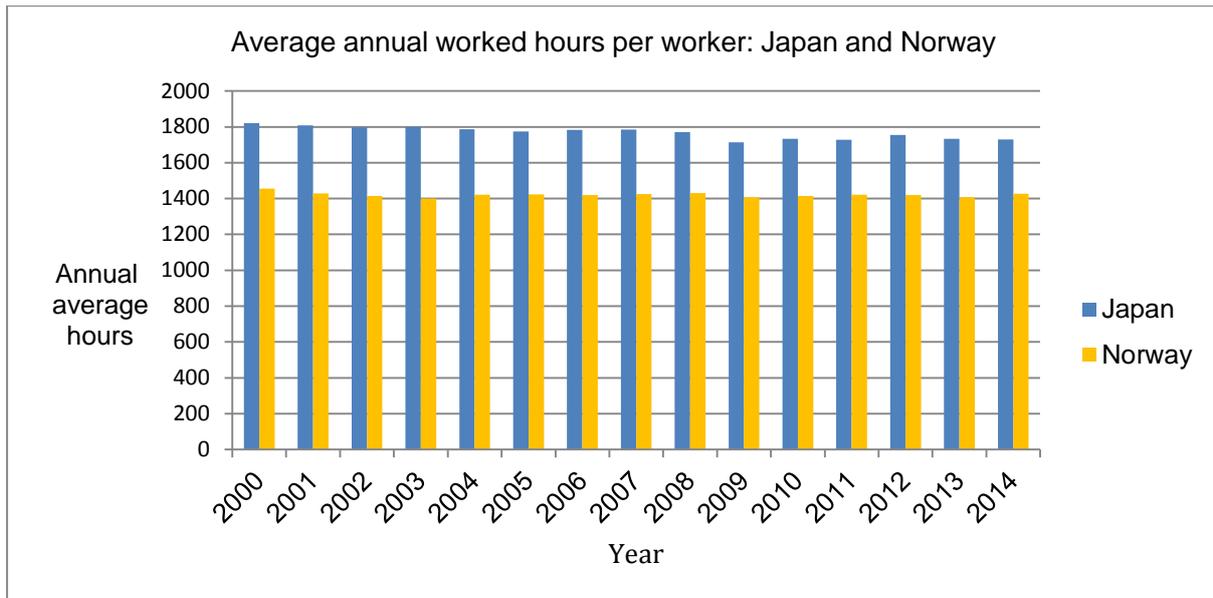


Figure 6: Average annual worked hours per worker: Japan and Norway

Source:

OECD. Stat; Labour, Labour Force Statistics (OECD, 2016)

Available at: <http://stats.oecd.org/index.aspx>

(Data extracted on 19/02/2016)

In 2000, Japanese workers worked 1821 hours and Norwegian workers worked 1455 hours annually (OECD, 2016). Since then Japanese workers' worked hours gradually have decreased while Norwegian workers' worked hours have remained about 1400 hours annually despite a slight decrease from the year 2000. In 2014, workers in Japan and Norway worked an average 1729 hours and 1427 hours annually (OECD, 2016). It seems that the Japan is making an effort to reduce the general working hours for all workers; however Japanese workers still worked 302 hours longer annually than Norwegian workers in 2014 (OECD, 2016). There is an unpopular and common practice in Japanese office as unpaid overtime, "sabisu zan-gyou", where some portion of workers' overtime is neither officially recorded nor compensated. Most likely those data of unpaid overtime would not appear in the data presented by OECD statistics. In general, Japanese workers would be working much longer than the data presented here. Since the specific data as mentioned above is not available, therefore, the trend could possibly be seen as appropriate for comparative purposes in respect of healthcare workers.

Strictness in employment protection

Figure 7 shows the index of the strictness of employment protection in Japan and Norway.

Definition of employment protection by OECD is mentioned below:

Employment protection refers both to regulations concerning hiring (e.g. rules favouring disadvantaged groups, conditions for using temporary or fixed-term contracts, training requirements) and firing (e.g. redundancy procedures, mandated pre-notification periods and severance payments, special requirements for collective dismissals and short-time work schemes) (OECD, 2002).

According to Cazes *et al.* (2015), OECD indicators of Employment Protection are “the most comprehensive, regularly updated, well known and widely used indicators in the area of Employment Protection Legislation (EPL)” (Cazes *et al.*, 2015: 59). OECD strictness of employment protection indicator of regular employment follows the value from 0 to the highest value of 6 (Cazes *et al.*, 2015: 59). The indicator uses 9 items to assess the strictness of employment on procedures at the time of the dismissals of regular employment, such as notification procedure, the length of the notice period, definition of justified or unfair dismissal and so forth (Cazes *et al.*, 2015: 95-97). Figure 7 presents the strictness of employment both for individual and collective dismissals on regular contracts in the years between 2000 and 2013. General protection of workers will tell us the status and working conditions of general workers, especially at the time of the dismissals. The analysis of the strictness of employment protection could apply to healthcare workers and migrant health care workers as well.

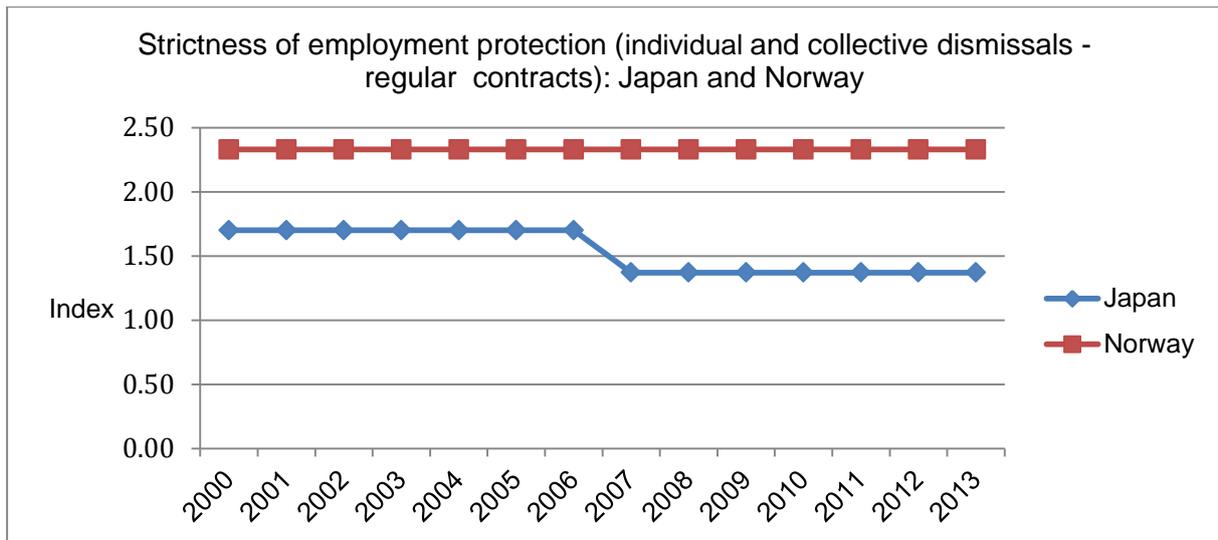


Figure 7: Strictness of employment protection (individual and collective dismissals – regular contracts): Japan and Norway

Source:

OECD. Stat; Labour, Employment Protection (OECD, 2016)

Available at: <http://stats.oecd.org/index.aspx>

(Data extracted on 12/06/2016)

Norway’s index remains same as 2.33 from 2000 till 2013 while Japan’s index drops to 1.3 in 2007 from 1.7 over the previous year (OECD, 2016). The sudden drop in the index could be the effect of a reform or revision of the law, which will be discussed later. This shows the high degree of stricter regulation on employment protection in Norway than in Japan.

Job quality by the level of education

Table 3 shows the data about the quality of the working environment of Japan and Norway categorised by the level of education in 2005. The job quality is measured by the degree of job strain occurring to workers. The job strain is defined as “jobs where workers face more job demands than the number of resources they have” (OECD, 2005). The high level of job demands has two components: time pressure and physical health factors. While the low level of job resources has two components: work autonomy with learning opportunity and social support at work. OECD (2005) explains the terms as below: 1) *time pressure* as inflexible and long working hours and severity in work; and 2) *physical health risk factors* as harmful and tough work, such as exposing to extreme temperature, chemical and noise, keeping pasture

which is harmful as well as tiring and lifting heavy goods; 3) *work autonomy and learning opportunities* as the degree of workers' autonomy to decide the ways of processing task and the availability of the workers' learning opportunities and 4) *social support at work* as the availability of social support for workers provided by their seniors and co-workers (OECD, 2005). The Job Strain Index is made up of the degree where workers face a high level of job demand and low level of job resources (OECD, 2005). As healthcare sector represents labour intensive work, the table seems relevant.

Table 3: Quality of the working environment by education levels: Japan and Norway

Age		Total							
Sex		Total							
Time		2005							
Overall measure		Quality of the working environment							
Components		Job Strain	Job Strain						
		High level of job demands	High level of job demands		Low level of job resources	Low level of job resources			
			Time pressure	Physical health risk factors		Work autonomy and learning opportunities	Social support at work		
		Unit	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Country	Education								
Japan	High skilled	48.31 (C)	..	64.04 (C)	..	11.22	37.38 (C)	..	
	Medium skilled	37.53 (C)	..	48.48 (C)	..	6.98	20.03	32.27	
	Low skilled	58.96 (C)	..	58.05 (C)	..	2.27	10.73	21.78	
Norway	High skilled	24.89	8.95	50.7	13.69	20.92	51.1	37.82	
	Medium skilled	23.97	12.92	37.93	20.11	18.69	41	42.1	
	Low skilled	44.15	29.56	48.68	47.69	14.15	27.36	42.76	

Source:

OECD. Stat; Labour, Job Quality (OECD, 2016)

Available at: <http://stats.oecd.org/index.aspx>

(Data extracted on 19/02/2016)

Several insights have been identified from the above. Some data from Japan are not available, therefore available data are analysed below. The first column shows the composite job strain indices followed by detailed components as a high level of job demands and low level of job

resources, in which each degree is expressed by percentage. The job strain indices are overall higher in Japan than in Norway. Both low-skilled workers from the two countries face more job strain than other groups, Japanese low-skilled workers are presented by 58.96% and Norwegian colleagues mark as 44.15% (OECD, 2016).

Second, the time pressure on Japanese high-skilled workers are remarkably high as 64.04% followed by 58.05% for low-skilled worker (OECD, 2016). Norwegian high-skilled workers face higher time pressure as 50.7% and low-skilled workers as 48.68% (OECD, 2016).

Third, on the level of job resources, overall, Japanese workers receive much fewer resources than Norwegian workers. The table shows that Japanese workers receive job resources for high-skilled 11.22%; medium-skilled 6.98% and low-skilled 2.27% (OECD, 2016). While Norwegian workers receive much more job resources as 20.92%, 18.69%, and 14.15% respectively (OECD, 2016). Furthermore, on the job resources, the proportion of Norwegian workers is about 10 percentage points higher than Japanese workers. Thus, generally Norwegian workers enjoy more autonomy, learning opportunities and social support at work than Japanese workers.

It is evident from above that Japanese workers face more job strain than Norwegian workers. This is explained by higher job demand and lower job resources for Japanese workers and lower job demands and higher job resources for Norwegian workers.

5.5 Labour laws enforcement

5.5.1 Japan

Trainees and Interns system to bring foreign workers in Japan

As described above, the Japan does not conduct the international recruitment of nursing care or care workers and low-skilled workers as of June 2016. EPA was agreed on Japanese assistance for the foreign healthcare workers to obtain the Japanese qualification (JICWELS,

2015). As no legal system for recruiting the workers existed in Japan, therefore, the EPA became a gateway to accept those workers as the trainees. According to the report of NRI of Japan, Japan does not conduct international recruitment for the nursing care or care worker (WHO, 2012, 2015). It also has not ratified the ILO Conventions related to migrant workers and nurses (ILO, 2016a).

In fact, already a good number of foreign migrant workers in Japan exist who were brought as trainee and technical intern in other industries (Akashi, 2011; Asato, 2011a). As described earlier, they engage in 3K jobs with lower wage than the legal minimum wage and poor working conditions. What's more, Yasuda (2010) reports that they often receive physical or psychological harassment by employers and intermediaries. The official purpose of the trainee and technical intern under the agreement with other countries is the international contribution through technology transfer (Yasuda, 2010). However, as mentioned above, the reality of this training and internship program is much different from the official purpose (Ishihara, 2009; Yasuda, 2010). Thus, Yasuda (2010) concludes that current migrant labour practice represented by training program in Japan is based on the two sets of rules. The first one is, no recruitment of migrant workers and the second one is bringing these workers as trainee or intern and then placing them as workers (Yasuda, 2010). Similarly, the EPA is another legal passage of the nursing or care workers who are not recruited from abroad. This situation creates opportunities for employers and intermediaries which defies the spirit of labour laws applicable to foreign workers.

Enforcement of labour related laws in Japan

Labour Standard Act and *Employment Security Act* are weak in enforcement. Japan has several legal and institutional systems in place to enforce labour laws. For example, Ihara (2016) explains that the Labour Standards Inspection Office has labour standard inspector with strong authority to inspect workplaces in order to check any illegal activities in

contravention of labour laws. Visits of labour standard inspector are both with prior notice and without prior notice (Ihara, 2016). However, this author observed that the inspector informed before visiting institution. Nagayama (2009) pointed out that post-war *Labour Standard Act* and *Employment Security Act* have never been implemented as binding instruments in letter and spirit. In addition, Japan has ratified less ILO Conventions and have not implemented the WHO Global Code of Practice on the International Recruitment of Health Personnel. It is not out of place to mention here that the rise of “Karoshi” (death from overwork), marked a record of 1,456 deaths in 2015 (Reuters, 2016). Cases of Karoshi include healthcare, social services, shipping, and construction sectors. Karoshi is described as a cardiovascular death after 100 hours of overtime during the previous month or after 80 hours of overtime continuously in several months and a suicide after 160 hours of overtime in one month or after more than 100 hours of overtime for three succeeding months (Reuters, 2016).

Japan does not have special labour courts, therefore, labour legislations are interpreted and dealt with by ordinary courts (Jung, n.d.). Thus, the verdict over labour disputes could depend on the legal interpretation made by the ordinary courts. Japan not only lacks in the strong legal enforcement of labour laws and clear and explicit migrant policy, but also lacks in institutional arrangement to deal with overall labour issues.

5.5.2 Norway

Social dumping

Among Nordic countries, including Norway, there is the practice of ‘social dumping’ since the expansion of EU through new membership of Eastern European countries (OECD, 2014). Bernaciak (2012) clarified the main actors of social dumping were enterprises, who degraded ‘social standard’ (Bernaciak, 2012: 24) in order to gain business competence. They pursued amendments to the regulations of host countries, which compelled workers to engage on

lower remuneration (Bernaciak, 2012). According to OECD (2014), the evidence of such exploitation practices for migrant workers from EEA countries exists. Examples of the practice are non-compliance on legal minimum salary, overtime work without compensation and inappropriate working conditions (OECD, 2014). Furthermore, OECD (2014) reported that Eastern European workers consisted one fifth of total deaths at Norwegian workplace in 2012. It was because majority of them worked at high-risk workplaces without sound knowledge of local language and safety measures (OECD, 2014). The OECD report does not cover any incidence of social dumping of non-EEA migrant healthcare workers. However, such practices with the non-EEA migrant healthcare workers might exist due to their vulnerable socio-economic status.

Enforcement of labour related laws in Norway

Norway recruits foreign workers and accepts labour migration (UDI, 2016) Therefore, Norway has developed laws and regulations on general migrant workers. As the future shortage of nurses is projected (Ramm, 2013), Norway is therefore keen to recruit foreign nurses through the utilisation of simplified digital application process (Helsedirektoratet, 2016; UDI, 2016). Furthermore, Norway has ratified ILO Conventions related to not only general migrant workers, but healthcare workers (ILO, 2016a). In addition, it has implemented *WHO Global Code of Practice on the International Recruitment of Health Personnel* (WHO, 2012, 2015) and *EU Directive 2008/104/EC of the European parliament and of the Council of 19 November 2008 on temporary agency work* (Hveding and Johansen, 2016). Thus, Norway has more developed labour migration policies than Japan.

Furthermore, Norwegian labour laws and regulations have mechanisms to enforce the rule of law, for example on working conditions, occupational safety and health by several legal and institutional set-ups as described below: 1) the Norwegian Labour Inspection Authority (Arbeidstilsynet), which carries out the compliance of the provision of the *Working*

Environment Act (Arbeidstilsynet, 2016); 2) the Labour Court of Norway (Arbeidsretten); a special and highest court to deal with labour disputes, which was established in 1915 (Arbeidsretten, 2016); 3) the Parliamentary Ombudsman for Public Administration (Sivilombudsmannen); public administration agencies which conduct supervision based on citizen's complaints against malpractice of public offices (Sivilombudsmannen, 2016) and 4) the corporatist system moreover ensures the enforcement through active and powerful labour organizations and negotiations of comprehensive agreements among state, organizations of employee and employers (Mailand, 2009). Norwegian human rights law has incorporated the *European Convention on Human Rights* which is relevant to the working conditions and subjects Norway to the European Court of Human rights (*European Convention on Human Rights* 1950) Therefore, it appears that Norwegian labour laws are indeed enforcing.

5.6 Influence by NPM on health policy

5.6.1 Japan

Koizumi regime (2001-2006) launched the neoliberal healthcare reforms from 2001 to 2006, which introduced the market system in the healthcare sector (Japan Medical Association, 2006). Niki (2007) narrated that since the introduction of this reform, Japan has become a state where patients bore the highest burden of healthcare expenditure among G7 countries. Japan has implemented separate cost containment policies in the health sector before the reform (Niki, 2007). The medical reform in 2001 intended to achieve both the improvement in the quality of health care and the reduction of healthcare cost through radical reforms (Niki, 2007). According to Japan Medical Association (2006), the healthcare reform focused on following four objectives:

- 1) 'control on medical benefits' through continuous reduction of medical expenditure, introduction of mixed practice associated with reduction in public healthcare insurance coverage and restructuring the nursing care facilities

- 2) 'increase in healthcare fee payment borne by household' through increase in health insurance premium and co-payment
- 3) 'introduction of new methods into public administration for healthcare cost control' by establishing the social security number, healthcare cost management system and access of health related information of the insured to the insurer
- 4) 'profit transfer of health sector to private enterprises' through introduction of mixed practice and opening health facilities ownership to corporations by regulatory reform (Japan Medical Association, 2006, translated by the author).

Japanese healthcare reforms have been dominated by the concept of cost efficiency and marketization (Yoshihara, 2009). It may be noted here that complete implementation of the reform did not happen, however, radical healthcare cost-cut has continued (Niki, 2007). As a result, universal healthcare insurance system has started to break down with the gradual increase in the number of uninsured (Niki, 2007).

5.6.2 Norway

Ringard *et al.* (2013) and Spehar and Kjekshus (2012) describe how the Norwegian healthcare system has special characteristics. First, Norway has decentralised healthcare system, however, the specialist care was centralised in 2002 (Ringard *et al.*, 2013). Second, the state spends 85% on health expenditure through public sources (Ringard *et al.*, 2013). Third, Norway shows the influence by NPM movements which led Norway to the major healthcare reforms (Spehar and Kjekshus, 2012).

Major points of Norwegian healthcare reform in 2001 and 2002 are listed below.

1) List patient reform-GP (2001): Carlsen and Frithjof Norheim (2009) explained that the List patient reform aimed at equitable geographical access to citizens in primary care through the explicit listing of patients. The reform enhanced GP's role in primary care and coordination

for referral (Carlsen and Frithjof Norheim, 2009). The state gave financial incentives to GPs of 10% increase in activity based fee reimbursement (Carlsen and Frithjof Norheim, 2009).

2) Hospital ownership reform (2002): Hagen and Kaarbøe (2006) pointed out that the Hospital ownership reform focused on the efficient healthcare service delivery at specialist care with three elements. One, the reform gave the ownership of all hospitals providing specialist care to the state which were with the counties earlier (Hagen and Kaarbøe, 2006). Two, under the restructured scheme, all hospitals were kept under five (later four) Regional Health Authorities as legally independent public enterprises (Hagen and Kaarbøe, 2006). Three, the minister of health took charge of management of specialised care hospitals (Hagen and Kaarbøe, 2006). Hagen and Kaarbøe (2006) and Johnsen (2006) pointed out that the reform had both centralisation and decentralisation aspects. The centralisation aspect is central government ownership of specialist care which used to belong to the counties (Hagen and Kaarbøe, 2006; Johnsen, 2006). Whereas the decentralisation aspect is delegation of authority to the Regional Health Authorities over hospitals with independent management hired from private sectors (Hagen and Kaarbøe, 2006; Johnsen, 2006).

The reforms of 2001 and 2002 overall focused on managerialism on NPM elements. The managerialism of NPM highlights enhancing better management and reorganising the structure of the organisation (Larbi, 1999). Examples of managerialism are clear goal setting of performance, organised and careful use of resources and promoting independent management professionals (Larbi, 1999). The 2001 List patient reform targeted the equitable healthcare service through establishing the complete patient list and improvement in GP's coordination for referral (Carlsen and Frithjof Norheim, 2009). The 2002 Hospital ownership reform aimed at efficient healthcare service through restructuring of the healthcare organisation and regaining the state ownership of hospitals (Hagen and Kaarbøe, 2006).

However, the state ownership of hospital represents centralisation, so this reform is not completely a part of NPM, because NPM advocates “decentralisation of management authority” (Larbi, 1999). Norwegian healthcare reform focused on some managerialism elements of NPM. It may be noted here that Norway selected strategic policies carefully which were desirable for the healthcare system.

5.6.3 Summary of influence by NPM in Japan and Norway

In light of the above, it appears that Japan has implemented market policies of NPM, whereas Norway has focused on managerial aspects of NPM. It may also be mentioned here that Norway has been obliged to implement many EU Directives, Regulations and Decisions. Thus, Norway is bounded by EU rules in many areas. Furthermore, Norway is active to ratify ILO Conventions according to the state’s choice on a case to case basis. On the other hand, EU rules are not applicable to Japan; therefore Japan does not have any obligation to implement them. In addition, Japan is not active in ratifying ILO Conventions. Thus, Japan has shown reluctance to make the same choices as those being made by Norway.

6. DISCUSSION

6.1 Major findings

The research question in this study is, as to how the regulatory framework for the international recruitment of healthcare workers with its differences and similarities in many ways can affect the working conditions of the migrant healthcare workers. Since Japan and Norway are ageing societies, therefore there is a need to increase healthcare workers. However, both the countries have developed regulatory framework for healthcare workers from overseas differently, so the working conditions are not similar for migrant/foreign healthcare workers in the two countries.

Japan does not recruit migrant healthcare workers such as nurses and care workers, however through EPA Japan has a pathway to bring those healthcare workers from overseas as trainees. After qualifying Japanese professional examination, EPA healthcare workers can stay in Japan. But currently there is no passage for them to get permanent resident status, which discourages them to stay for longer duration. These contradictory rules on recruitment of foreign healthcare workers shows Japan is ignorant of the relevant regulatory framework on migration of healthcare workers. This indicates Japan's reluctance to maintain international standards advocated by several international organisations. In addition, weak enforcement of labour laws promotes employers' exploitation of workers among 3K industries. In view of less workers, the burden shifts to the locally employed, which has resulted in death by overwork - karoshi. Thus, those regulatory frameworks have affected not only migrant but local healthcare workers as well.

Norway recruits migrant healthcare workers and has developed relevant regulatory framework for them. Based on realisation of limited resources and the importance of equal treatment of migrants, Norway has been active to adopt the international standards relevant to the working conditions of migrant healthcare workers and have incorporated those under the relevant

regulatory framework. Besides, Norway has been a prudent reformer in the health sector which has enabled it to maintain good working conditions, shown by statistical data.

The objective of recruiting foreign healthcare workers in Japan and Norway is different. Japan's objective is to fill the shortage of healthcare workers through foreign trainee's programme at low cost and without much effort to make changes in the current regulatory framework. This arrangement allows Japanese government to be reluctant to develop a relevant regulatory framework as well as institutional capacities dealing with migrant healthcare workers. It is evident from literature, especially the survey of NRI conducted by WHO in 2012 and 2015 where Japan responded that it did not need to implement the Code because Japan had never recruited foreign healthcare workers (WHO, 2012, 2015). Furthermore, EPA is carefully designed not to increase public expenditure as its major cost is borne by host health institutions. The Japanese government has a strong belief that labour intensive health service can maintain high quality healthcare service while reducing the healthcare expenditure. However, Niki (2007) confirmed that this theory had been denied in studies conducted in other developed countries.

While the objective of Norway is to recruit migrant healthcare workers granting the same labour rights as for local healthcare workers. Norway has accepted and is accepting immigrants and labour migrants; therefore Norway has developed relevant institutions and regulatory framework. Besides, Nordic cooperation and EEA agreements make Norway obliged to maintain the international standard related to human rights of migrant healthcare workers. The Norwegian government has focused on managerial reforms on health sector than cost efficient market reforms. Papademetriou (2004) claimed that the philosophy of egalitarianism has been maintained for Norwegian migration policy over the years.

Thus, the objectives of health sector policy in Japan and Norway are different and therefore have affected the ways for formulating their regulatory frameworks. It is indeed important to acknowledge this fact for analysing any policy comparison because it explains the causes of the current situation and suggests the possible policy implications.

6.2 The matrix model of NPM effects on recruitment of migrant healthcare workers

The analysis about the effect of NPM on the healthcare system and migrant healthcare workers is shown in Figure 8. It presents the position of Japan and Norway in the matrix model of NPM effects on recruitment of migrant healthcare workers. The model consists of two continuums: the continuum of managerialism and marketisation at horizontal axis and the other continuum of equal treatment of the healthcare workers and economic efficiency of the healthcare system at the vertical axis. Managerialism encourages better organisational management through reorganisation of the system. While, marketization focuses economic efficiency through the introduction of private sector management (Larbi, 1999). The first continuum shows how Japan and Norway are inclined towards managerialism or marketization in their healthcare system policies. Another continuum shows NPM effects on healthcare policy of Japan and Norway. It particularly presents inclination towards treating migrant healthcare workers equally or focusing on the economically efficient healthcare system. NPM has replaced the value of public sector governance such as social security and social cohesion by economic efficiency and individual responsibility (Du Gay, 2000). The value change in public governance in two countries after the emergence of NPM is relevant to this study. It is very important to observe how Japan and Norway has parted the way of developing health sector's regulatory framework which has resulted in the difference of migrant healthcare workers' working conditions.

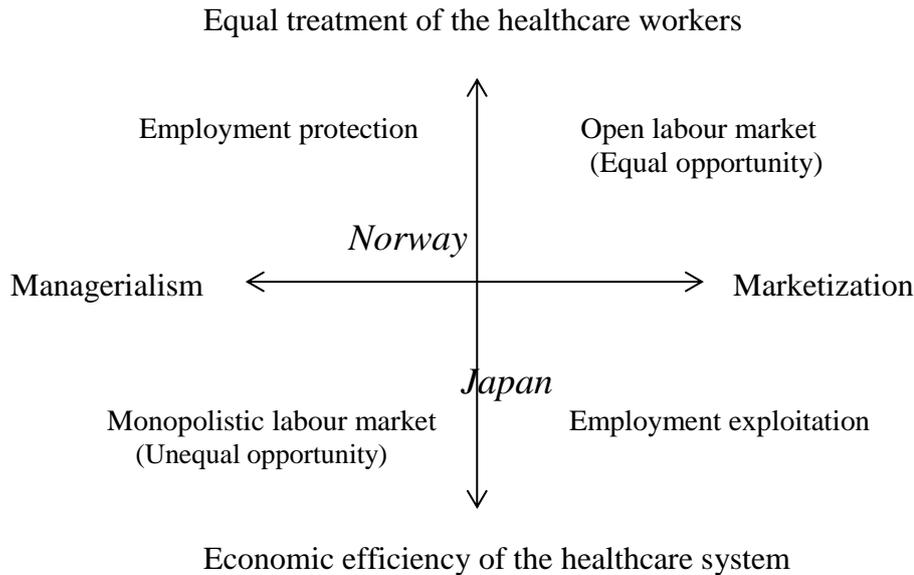


Figure 8: The matrix model of NPM effects on recruitment of migrant healthcare workers in Japan and Norway

6.2.1 NPM effects on migrant healthcare workers in Japan

Japanese healthcare policy has focused on economic efficiency. This is evident from decades of cost reduction in healthcare expenditure following the introduction of marketization of NPM, since early 2000 (Japan Medical Association, 2006; Niki, 2007). Moreover, Japanese government has successfully persuaded local healthcare workers to bear low remuneration and to work longer hours. Their poor working conditions along with other 3K professions are evident from the literature and statistical data introduced into this study. This study reconfirms that the introduction of the market system in the healthcare sector has brought the regulatory framework to exploit healthcare workers. Moreover, weak enforcement of labour laws has aggravated their working conditions which have caused the shortage of local healthcare workers by their high turn-over. As a result, Japan justifies filling the gap by the EPA healthcare workers coming from poorer working environment, without improving the working conditions locally (Endo, 2009).

Japan is at the crossroad of either continuing the same path or building sustainable employment policies on healthcare workers. Japan needs to acknowledge the fact of its recruiting foreign healthcare workers. This stance leads Japanese government to develop policies and regulatory framework related to all healthcare workers regardless of their residential statuses. Japanese researchers discuss issues of migration policy and present their suggestions for resolving the issues in their publications (Asato, 2011b; Gaikokujin Rōdōsha Mondai to Kore kara no Nihon Henshū Iinkai, 2009).

6.2.2 NPM effects on migrant healthcare workers in Norway

Norwegian healthcare policy has put more emphasis on equal treatment of local as well as migrant healthcare workers. This is evident that Norwegian health reform has not taken a passage of NPM inspired market reform as Japan has, rather followed organisational restructuring. This is because Norway has been bound by many rules and Directives enforced by Nordic cooperation and the EEA agreement. In addition, Norway has been enforcing labour laws in the aid of domestic legal mechanisms and implementation of international rules and guidance. Overall Norway has managed better working conditions for migrant healthcare workers, keeping in view, the recent development of the revised *Working Environment Act* (2015) has allowed employers to hire workers with temporary employment without any prerequisite (Steen, 2015). Increase in the number of contract workers in the public sector is seen as marketization in the healthcare sector. Larbi (1999) clarifies that the change in employment form from permanent to contract is considered as marketization.

In light of the above, Norway has carefully designed health and migration policies and regulations along with efforts to protect migrant healthcare workers and to reduce their vulnerabilities. It is obvious that Norway has fared well by managing the regulatory framework for migrant healthcare workers appropriately. This process adopted appears inclined to managerialism where employment protection and equal opportunity has been

insured. However, recent development suggests that some elements of marketization are being gradually introduced in the system.

7. CONCLUSION

International recruitment of healthcare workers in Japan and Norway is a broad subject which includes: healthcare system reforms, migration policies including relevant laws and regulations. Main factor causing poor working conditions in Japan is the result of reluctance to adopt international standards relating to labour laws. In contrast, Norway is active in ratifying international conventions, providing better working environment which reduces vulnerability of workers. Poor working conditions in Japan can be further explained by the strong endorsement of ‘individual responsibility’ advocated by NPM marketization by Japanese workers. Traditional cultural value in Japan is taking responsibility of own affairs, not bothering other people, in other words, perseverance is highly appreciated in Japanese society. This value has matched with individual responsibility, which has silenced many Japanese workers from raising their voices against their poor working conditions. While Norway has developed a strong sense of human rights, egalitarianism and mechanism of enforcing labour laws. Workers in Norway enjoy the basic labour rights, and they are able to demand and demonstrate their rights effectively. The working environment of local healthcare workers matters more with migrant healthcare workers because of their vulnerable socio-economic status. Message has been conveyed in this study for the need of serious re-examination in applying market mechanism in the health sector where highly labour intensive service deals with unpredictable human health. Thus, it is unable to bring complete efficiency like other industries, while bringing misery to healthcare workers and their service recipients.

Difficulty in this study was to find the comparable statistical data on the working conditions of migrant healthcare workers between two countries. Statistical data showing the strength of labour act in Japan and Norway could be a significant evidence of labour situation. However, only the available union density was insufficient to do so without other supportive data for

analysis since it required careful interpretation. Another constraint in this study was less similar work on migrant healthcare workers written in English which could have been investigated. Therefore, this study has a role to introduce the studies written in Japanese. In addition, it provides a comparison between Japanese and Norwegian situation on the international recruitment of healthcare workers. Efforts to establish standardised methods of collecting statistical data on general employment practice and working environment for both migrant and local healthcare workers will be beneficial for future relevant studies. At the end, it is suggested that studies written in English on similar subject but from different angles will encourage new entrants of researchers having diverse views.

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