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Japan's biopolitical crisis: care provision in a transnational frame

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Keywords
frame, crisis, transnational, biopolitical, japan, provision, care

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Care Provision in a Transnational Frame

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Abstract: In this article I consider recent policies on care provision in Japan, including the employment of immigrant workers. My discussion is framed by Michel Foucault's concepts of 'biopower' and 'biopolitics': a mode of governmentality focused on the management of populations. In the current age of economic globalisation, however, biopolitics also crosses national boundaries. Raewyn Connell has described a 'global gender order' whereby gender relations are shaped by power structures which transcend the level of the nation-state. This involves the connections between different local gender orders and gender orders which transcend the scale of the nation-state. The migration of care workers involves gendered structures in both sending and receiving countries, in interaction with other dimensions of difference, including class, caste, ethnicity and racialised positioning. In order to understand the relationships between the providers and receivers of care, it is necessary to bring together the insights of the nation-focused concept of biopolitics and the multileveled perspective of the 'global order of inequality' and the 'global order of difference'. Between the local and the global, there are also regional orders of inequality and regional orders of difference; and care work involves relationships which are put into practice at local, intimate, interpersonal and embodied levels.

Keywords:

Biopolitics

Gender

Care work

Globalisation

Migration

Japan

A Crisis of Love?

A few years ago, a book appeared in Japan with the slightly shocking title *The Country Without 'Love'* ('Ai' naki Kuni).[1] The book (and television documentary) explored the crisis in aged care in Japan, reporting on the high turnover rate in the caring profession (NHK Supesharu Shuzai-han and Sasaki 2008). The invocation of the concept of 'love' captured the paradox of care work in the early twenty-first century. Care work has hitherto been associated with the family and the home, and seen as an expression of familial love, but has gradually been transformed into a form of paid work. One of the reasons that the carers described in the book were leaving their jobs was a simple economic one: the small wages they received as non-regular workers. The problem of care provision, however, is more than an issue of the individual choices of workers and their employers. Rather, it concerns demographics and the management of populations. The 'deep crisis in care systems worldwide' (Truong, Wieringa and Chhachhi 2006: xxi) can no longer be solved within the boundaries of one nation-state, but needs to be placed in the context of the comparative economics, demographics and biopolitics of the countries which send and receive care workers.

In Japan, as in other modern capitalist societies and economies, the management of the population has been a dominant concern. This exemplifies Foucault's insight that the 'adjustment of the accumulation of men [sic] to that of capital, the joining of the growth of human groups to the expansion of productive forces and the differential allocation of profit, were made possible in part by the exercise of bio-power in its many forms and modes of

application' (1990: 140–141). Since the late nineteenth century, Japanese governments have been concerned with the management of capital, the management of populations and the disciplining of subjects. In the early twentieth century, the focus was on eugenics (Robertson 2005: 329–354); colonialism deployed the labour power of colonial subjects; while the total war effort of the 1940s focused on population growth (Miyake 1991: 267–295). After the Second World War, the eugenic focus returned with an emphasis on population limitation and family planning (Ogino 2008). Currently the issue is how to deal with an aging population, a shrinking workforce and a plummeting birthrate.

The techniques of power over populations also act 'as forces of segregation and social hierarchization, exerting their influence …[and]… guaranteeing relations of domination and effects of hegemony' (Foucault 1990: 141). In order to gain insights into these forces of 'segregation and social hierarchization', it is useful to supplement the concept of biopower with other theoretical concepts, particularly when considering the current age of economic globalisation, where the management of capital and labour and the workings of biopolitics cross national borders.

Raewyn Connell has described a 'global gender order', where gender relations are shaped by power structures which operate beyond the boundaries of any one nation-state (2009: 127). In order to understand labour migration, it is necessary to come to terms with the local gender orders in both sending and receiving countries, and the regional and global gender orders which transcend the scale of the nation-state. Gender also interacts with other dimensions of difference, including class, caste, ethnicity and racialised positioning. With a focus on socio-economic structures, we might call this 'the global order of inequality'; with a focus on the cultural constructions of difference which accompany and produce inequalities,

then 'the global order of difference' might be an appropriate label. The policies of national governments and the choices made by individual workers and their employers work together to produce orders of difference at local, regional and global scales.

The Biopolitical Crisis

The Japanese government attempts to manage the population through policies on family, reproduction, labour, work-life balance, welfare and border control. These forces are currently in disequilibrium, with an aging population, a plummeting birthrate, a shrinking labour force, and several decades of economic recession. The crisis of care has been exacerbated in the wake of the earthquake, tsunami and nuclear incidents of March 2011 which have affected impoverished rural areas with disproportionately high numbers of the aged (Ôtani 2012: 237–254; '52 nursing homes in Iwate, Miyagi shut after disaster' 2011: unpaginated). Until the mid- to late-twentieth century, it seemed that Japanese governments had been successful in population management, with good nutrition, healthy populations, high educational levels, high life expectancy, low unemployment and high economic growth levels. This very 'success', however, is what has led to the current demographic crisis.

Japan's total fertility rate – the average number of children born per woman aged between 15 and 49 – dropped continuously until the early 2000s: 2.16 in 1971, 1.29 in 2004, down to 1.26 in 2005, then inching up to 1.37 in recent years. Until recently Japan had the highest life expectancy in the world: now at 85.9 years for women and 79.44 years for men ('Japanese women fall to second after Hong Kong in longevity rankings; 3/11 said a factor' 2012: unpaginated). Young people are marrying later, having fewer children, and starting families later. An increase in the number of irregular workers and the worsening employment situation also contribute to a reluctance to marry and have children. The population is

shrinking, and recent years have recorded more deaths than births. The number of households has risen, reflecting a large number of single-person households, particularly among the elderly. It is estimated that the population will shrink from the current level of around 128 million to about 90 million by 2055 (Statistics Bureau, Japan 2011: 11–25). There are two bulges in the population: those from the post-1945 baby boom who are at or close to retirement age; and those in their thirties, born in the secondary boom of the 1970s. People aged 65 or older accounted for 23.1 percent of Japan's total population in 2010, and this is projected to increase to around 35 per cent by 2050. In 2010 there were an estimated 16.8 million children under the age of 15, or 13.2 per cent of the population, marking a record low (Statistics Bureau, Japan 2011: 15).

If we add up the population under 15 and the population over 65 and divide this by the productive population (those from 15 to 64) we get a dependent population rate of around 50 per cent. The two thirds of the population of productive age have to work to support the other third who are too old or too young to work. The productive population is expected to decline from 80.73 million in 2010 to 45.95 million in 2055. This is a matter of economics (of paying for pensions, welfare and medical care from the taxes of a shrinking labour force) but also a matter of finding the labour power to deal with the physical care of the aged. In order to improve this ratio, Japan would need to raise its birth rate, raise its retirement age, and allow substantial increases in the immigration of people of working age (Huguet 2003: 107–124). The government's efforts to raise the birth rate have been ineffective (Roberts 2002: 54–91), with many commentators referring to a 'strike' on the part of young people who are delaying marriage and childbirth (Coulmas 2007: 5). This could be seen as a form of resistance to the forms of disciplining of national subjects which were prevalent until the late twentieth century. Young middle-class educated men and women are reluctant to participate in the marriage and family systems when they can no longer aspire to the permanent, full-time employment which was the ideal for much of the twentieth century.

Discussions of childcare, domestic labour and care for the infirm, the elderly and persons with disabilities often assume a gendered division of labour in a nuclear family based on a heterosexual couple, notwithstanding various challenges to these assumptions (Roberts 2002: 54–91). The never-married, widowed, divorced and those in non-heterosexual relationships become invisible in discussions of care (Kimoto and Hagiwara 2010: 202–229). Because women have a higher life expectancy than men, and tend to be younger than their husbands, it is most likely that wives will outlive their husbands and be responsible for their care. According to government statistics, bed-ridden elderly relatives are cared for by: husband (13.3 per cent), wife (28.4 per cent), son (13.3 per cent), daughter (16.6 per cent), daughter-in-law (23.8 per cent), and others (4.7 per cent) meaning that in around 70 per cent of cases it will be a female who provides care (Sugimoto 2010: 170). Ideologies of gender make it seem 'natural' that women are the ones to provide care, whether as family members, volunteers, or paid carers.[2]

Consider a married couple of the 'baby boomer' generation where, according to the gender ideologies of mid-twentieth century Japan, the husband has been the primary breadwinner. They will have adult children, and possibly one or more grandchildren. It is likely that both partners' parents will be alive and in their late seventies. One or more of their grandparents might be still be alive and in their nineties. Paid work will be juggled with caring for the needs of aging parents and parents-in-law who may or may not live close by. Carers' insurance allows for casual or part-time paid help, but the burden of managing the activities and timetabling of relatives, paid carers and volunteers falls disproportionately on women.

In the 1980s, conservative governments promoted a so-called 'Japanese-style welfare state', where family-based care would be supplemented by volunteers. When it became apparent that the need for care work could not be met with family and volunteer labour

alone, a Carers' Insurance scheme was introduced to allow families to employ paid care workers (*Kaigo Hoken Hô*/Law Concerning Insurance for Nursing Care, 1997, amended 2000). Until recently, it seemed unimaginable that immigrant workers would be part of the solution for dealing with the crisis in elder care, but this has become a reality.

Care work has shifted from largely invisible unpaid work carried out by family members to a combination of family-based care, volunteer work, paid care and institutional care. Marketisation has been facilitated by the Carers' Insurance scheme. The market in caring labour is now a transnational one, involving both documented and undocumented migrant labour. Each stage in this process builds on, reproduces and in some cases transforms constructions of gender, class and ethnicity. Moving care labour from a purely family matter to a paid service results in the increased visibility of such work, but if this work is still carried out by a largely female workforce, then gendered assumptions are unchallenged. Class comes into play when we consider who purchases and who provides such services and who volunteers. Ethnicity comes into play in assumptions about the 'naturalness' of care work being carried out by Japanese nationals, as in some of the debates leading up to recent policy innovations. The question of ethnicity becomes more visible, however, when care workers are of non-Japanese nationality or ethnicity.

Biopower also concerns the construction and reconstruction of discourses of racialisation and the production of difference (Foucault 2003: 254–56). The attempts of successive Japanese governments to deal with labour shortages are intimately connected with racialisation. The promotion of volunteerism in the 1980s naturalised the assumption that Japanese people preferred to be taken care of by family members or volunteers of Japanese ethnicity. The 1990s policy to allow the short-term immigration of workers of Japanese heritage (largely in construction and manufacturing) was based on the unfounded assumption that these workers' Japanese ethnicity would minimise problems of dealing with

diversity. The promotion of limited, short-term immigration of trainees (*kenshûsei*) was another attempt to contain difference through limiting the official numbers of such trainees and limiting their length of stay. The current policy of allowing small numbers of trainee nurses and carers through bilateral economic partnership agreements is a similar attempt to contain difference. The scale and forms of immigration through official channels are being closely controlled and monitored, but there are also various unofficial channels (Piquero-Ballescas 2009a: 127–138).

Defining Care Work

Paid work no longer – if it ever did – conforms to the pattern of a wage labourer employed by a large manufacturing corporation. In Japan, there was a shift through the twentieth century from agriculture to manufacturing to services and information. In advanced economies, hospitals and schools 'now count *more* in forming our image of wage employment than factories and construction sites' (Nelson 2011: 5).

Writers from different theoretical frameworks have various ways of describing non-industrial or post-industrial modes of work. In Marxist terms, reproductive labour is all of the work which goes into the reproduction of labour power. This includes the domestic work (often carried out as unpaid work by female family members) which allows the worker (often characterised as a male breadwinner) to devote full energy to paid work during the working day. The term reproductive labour is ambiguous, however, referring variously to social reproduction, the reproduction of labour power, or biological reproduction. I prefer to reserve the term 'reproductive labour' solely for biological reproduction, which is also becoming increasingly commoditised, as people travel from richer to poorer countries or to countries with different regulatory regimes to purchase sperm or ova, to access reproductive technologies, to employ the services of a gestational mother, or to adopt a child (Whittaker

2009: 319–332). Many authors understandably find it useful to use an umbrella term which brings together various forms of feminised labour (Parreñas 2012: 269–275). However, it is also useful to focus on the specificities of different forms of labour. As Nicola Yeates notes, 'the sex trade tends to be unregulated, labour intensive, unskilled and atomized', while the professional nursing trade 'involves skilled labour, is regulated and corporatized and supplies capital-intensive operations' (2012: 140). One might add that most forms of feminised labour could conceivably be replaced by male labour (Glenn 1992: 1–43), but this is not true of gestational labour.

The term 'immaterial labour' (Hardt and Negri 2004: xvi) eloquently captures the shift from industrial to post-industrial capitalism, but we also need more nuanced terminology to understand 'gender, racial[ised], class and other power relations in the context of global economic transformations' (Boris and Parreñas 2010: 2). Emotional labour refers to face-to-face situations where 'one displays certain emotions to induce particular feelings in the client or customer' (Hochschild 2003; Boris and Parreñas 2010: 6). This intersects with 'intimate labour', entailing 'touch', 'bodily or emotional closeness', and 'personal familiarity' (Boris and Parreñas 2010: 2). Such work has often been considered to be a non-market activity or has been assigned a low market value, performed by those who are marginalised in terms of gender, class, ethnicity, racialised positioning, migrancy, visa status or nationality. The association of such work with marginalised workers, in turn, reinforces the devaluation of such work. In discussions of care work in a global context, this is often discussed in terms of care work being provided by 'women of colour' (Robinson 2011: 44). This makes sense in North America or Europe, where racialised difference is understood in terms of 'colour'. This formulation is less clearly applicable in East Asia, however, where there are specific

dynamics of ethnicisation and racialisation, not necessarily expressed in chromatic terms (Mackie 2009: unpaginated).

The care worker 'provides a service to someone with whom he or she is in personal (usually face-to-face) contact' (England and Folbre 1999: 40). Phrases including the word 'care' ('to care for'/ 'to care about'/ 'to take care of') can also imply the emotional element of such work. Caring work may be carried out on a paid or unpaid basis, by family members or non-family members, in the home or in institutions. While there are various Japanese-language equivalents for 'care work', such as the Sino-Japanese term *kaigo*, the English word 'care' has also been transliterated into Japanese in the compound '*kea rôdô*' (care labour). This often refers to care for the elderly and infirm, in the society where the aging of the population is the most advanced in the world.

Care Work and Labour Markets

In the latter decades of the twentieth century, Japan shifted to a largely post-industrial economy based on services, technology, knowledge, information and finance – described as 'cultural capitalism' (Sugimoto 2010: 20-21; 88–123). Manufacturing gradually moved offshore in search of looser environmental controls, weaker labour unions and cheaper labour power. Sub-contractors who stayed onshore employed a secondary labour force of married women in part-time or casual positions, seasonal rural labour and immigrant labour. The construction industry also became reliant on (largely undocumented) immigrant labour in these years, as employers evaded the numerous expensive benefits, entitlements and job security expected by regular full-time Japanese workers (Yamanaka 2000: 87–88).

Japan does not officially permit the immigration of 'unskilled' labour, but international students may engage in limited part-time work, and some workers enter the country as 'trainees' (*kenshûsei*). A special category for those of Japanese ancestry (*Nikkei-jin*) brought immigrants from Japanese-descended communities in Latin America to Japan as workers from the 1990s (*Shutsunyûkoku Oyobi Nanmin Nintei Kanri-hô* [Nationality and Refugee Recognition Law], as amended 1990). Despite their Japanese ancestry, these workers often came to Japan with limited Japanese-language skills and cultural competence, and thus were relegated to relatively unskilled occupations. In cultural terms, these *Nikkei* immigrants were seen as doubly subordinate: as descendants of impoverished Japanese farmers who had emigrated in earlier generations, and as contemporary citizens of countries seen as 'third world' in comparison with Japan (Tsuda 2004: 5).

It is seen as 'natural' that Japanese young people are increasingly reluctant to engage in manual work. The association of marginalised occupations with the least privileged members of society, including immigrant labour, allows members of the Japanese 'mainstream' to imagine themselves as fully middle-class, as engaged in white-collar 'mental' work rather than physical (embodied) work. Marginalised occupations come to be associated with particular ethnic groups, or, in other words, they are *ethnicised*. In the US context, the most physically demanding nursing tasks are often shifted 'onto low-paid and minimally trained (although often quite competent and caring) nursing aides, who disproportionately come from immigrant and minority racial groups'. This 'reinforces a mind/body hierarchical dualism, [and] reinforces racial and immigrant status divisions…' (Nelson 2011: 11). Similarly, in Japan, migrant workers are often relegated to the 'body' side of the mind/body dualism. However, this very dualism is unstable, for the need for such care work makes visible the embodied precarity of all humans who are subject to illness, impairment, disability and the aging process (Robinson 2011: 45).

Even under 'cultural capitalism', then, there is a need for work devoted to the care of individuals' bodily needs. Much of the discussion of immigrant labour in other parts of Asia has focused on domestic work (Piper 2004: 216–231; Moya, 2007: 559–579; Misra and Merz, 2005: 9), but the relatively flat income distribution in Japan meant that it was rarely feasible to employ domestic help. With the aging of the population and the plummeting birthrate, there is now a pressing need for the care of the aged and infirm. When commentators compare Japan with other parts of Asia, it is often in terms of 'working women' employing domestic labour (Cheah 2006, 178–266; Ohno 2010: 17). A full discussion, however, would start from the sexual division of labour and gendered ideologies in the home, and then situate this in the context of gendered, classed and ethnicised labour markets. In Singapore, for example, it is possible for working families to employ domestic workers due to economic disparities with neighbouring countries and state policies which regulate the employment of overseas contract workers. In Japan the 'double-burden' of childrearing and paid work has rather been handled by married mothers leaving the full-time workforce in the years when childrearing demands are heaviest, to return to the part-time workforce when children are older (Osawa 2005: 111–129).

Care provision can be transnational in several dimensions. Within Japan, this includes care provided to family members by spouses in international marriages, by documented or undocumented immigrant workers, and by expatriate family members who return to Japan from overseas at certain times of the year to assist with care for elderly family members. International marriage partners and immigrant workers are also engaged in 'global householding' through remittances and visits to their home countries (Douglass 2011: 19). Care provision also takes on a transnational dimension when the elderly reside overseas, through long-term emigration or through moving offshore on retirement. Relatively wealthy retirees from Japan move to Australia or Southeast Asia where they can access a more pleasant environment, more spacious residences and, in the case of Southeast Asia, the

services of care workers on a cheaper basis. In expatriate Japanese communities in places like Australia, volunteer organisations in the Japanese community are dealing with the needs of elderly Japanese migrants in partnership with local governments (Shiobara 2011: 406–408).

Many commentators see international marriage as a form of labour migration. Immigrant wives provide reproductive labour, domestic labour, and caring labour in their marital families, not to mention engaging in paid labour in their communities. Recently, such women are also undertaking training as care workers and will thus become the paid carers for other families (Piquero-Ballescas 2009b: 77–99). Women who had originally entered as 'tourists, entertainers, spouses/children of Japanese nationals, trainees or students' were, in effect, 'recruited as caregivers and providers of emotional labor in Japan' (2009a: 78). In a highly gendered labour market, women of the Japanese-Brazilian community, too, have apparently often been employed to provide informal personal care for the sick or elderly (Tsuda 2003: 294; 297).

While immigration categories are rigid, individuals find ways of moving between these categories. Someone might initially enter on a tourist visa, but overstay to engage in various forms of undocumented paid labour. Or, someone may have originally entered as an entertainer (under an earlier visa regime), but enter into a relationship which transforms her into the 'spouse of a Japanese national', and thus be eligible to apply for permanent residency. Regardless of government attempts to regulate the entry of various categories of residents, once within the boundaries of the Japanese nation-state, individuals inevitably form relationships with Japanese nationals or with other immigrants. The offspring of these relationships have been the subject of controversies concerning nationality and residence category (McNeill et al 2009: unpaginated). The Japanese government does not implement the kinds of restrictions on immigrant workers as Singapore does, for example, where population management involves prohibiting marriages between overseas domestic workers

and Singaporeans, prohibiting pregnancy, and testing for sexually transmissible diseases (Cheah 2006: 210). Such policies provide further justification for distinguishing different forms of feminised labour. The Singapore government *encourages* the employment of immigrants in domestic work and care work, but *discourages* their engaging in biological reproduction.

Behind the statistics is the reality of dealing with difference in everyday life. Power relationships are forged in daily encounters between partners in international marriages and their children and relatives, and between care workers and their clients. Gendered, classed and racialised hierarchies are produced through these daily encounters between individuals in unequal relationships. In the case of a younger care worker and an older client, age hierarchies are reinforced; in the case of a female carer and a male client, gendered hierarchies are reinforced; in the case of a working-class carer and a middle-class client, class hierarchies are reinforced; in the case of a non-Japanese carer and a Japanese client, ethnicised hierarchies are produced and reinforced.

Transnational Biopolitics

In order to understand the movements of migrant workers, it is necessary to understand the conditions in sending countries, and the conditions in Japan which produce the need and desire for such immigrants. In sending countries, we need to look at rural poverty, gendered labour markets, rural to urban migration – which easily becomes cross-border migration – the gap between economic conditions in different parts of Asia, and the effects of neoliberal structural adjustment policies on local economies. We also need to consider demographics in a transnational frame. The population pyramid of the Philippines, for example, is the reverse of Japan's. Life expectancy is 71.66 (74.74 for females; 68.72 for males). Only 4.3 per cent of the population are 65 years and over; 61.1 per cent are between

the ages of 15 and 64; and 34.6 per cent are 14 years or under. The fertility rate is 3.19. This means that there is a relatively young working population which can emigrate, but that these emigrants are often forced to leave the care of their children to family members or paid carers (Parreñas 2003; Hochschild 2003). To trace the routes of labour migration is also to map regional and global patterns of inequality:

> If the pull is the creation of demographics, of women's entry into the labor market, of the insufficient response of men to the demands of care, of inflexible work structures, and of levels of mobility that spread family members far and wide, the push is created by deeply unjust global economic forces that include a heavy indebtedness of poor nations, by the structural adjustment policies that cut services, gut public education, and drive the middle-class civil servants lower on the economic scale, by the various forces that have been responsible for increasing economic inequality globally, by governments that view the exportation of care workers as a significant source of revenue… (Kittay 2011: 119).

For countries such as the Philippines, Indonesia and Vietnam, the management of population involves an emigrant workforce and a dependency on remittances. For the governments of Japan (and South Korea and Taiwan), population management involves sourcing workers from poorer countries with a younger population structure in order to fill the gaps in care provision. It is in the interaction of these various national biopolitical regimes that regional and global orders of difference and inequality are produced.

In the 1990s, the temporary immigration of people of Japanese descent was seen as a more acceptable way of dealing with labour shortages than inviting 'guest workers' with no apparent ties to the Japanese nation-state. Although the Japanese heritage of such *Nikkei* immigrants was probably expected to cut down on problems generated by perceptions of difference, local communities soon found they had to deal with contact between groups with different social and cultural expectations, while schools needed to address the necessity of multilingual and multicultural education for the children of these families. Population management, here, was based on assumptions about the management of difference

(Yamanaka 2000: 71; Oka 1994: 41–49; Hatsuse 2005: 160).

Immigrant workers underpinned the production of cars and other export products, and many small firms and agricultural enterprises employed foreign trainees. The Japanese economy, however, was affected by regional and global economic crises. It was unable to sustain growth in 2008, due to a decline in export growth, and the economy recorded its first contraction since 2002. Corporate profits plunged and business investment fell. Unemployment rose until mid-2009, and most new positions created were part-time rather than full-time permanent positions, meaning that there has been little growth in wages, and a resulting lack of consumer confidence (Economic and Social Commission for Asia and the Pacific 2009: 143–5). The depth of the recession was July 2009, with some modest improvement from August 2009. Unemployment peaked at 5.7 per cent during 2009, and the automobile industry was hit particularly hard.

In April 2009 the government offered assistance to unemployed immigrant workers of Japanese ancestry who wished to leave the country. The government also allocated funds for training, including Japanese-language lessons, for the workers of Japanese ancestry. Some local governments started support programs for such workers, including plans to train unemployed members of the *Nikkei* community to work in nursing care ('Editorial: Support Needy Foreign Workers'. 2009). Immigration policy had 'created a labour force rigidly stratified by such collective characteristics as legal status, ethnicity, nationality, gender and skill level' (Yamanaka 2000: 63).

Economic Partnership Agreements

As a supplement to the care provided by family members, volunteers, paid carers and nursing professionals, the Japanese government is moving slowly on bringing in care

workers from overseas. This is being managed by bilateral agreements with Indonesia, the Philippines and, more recently, Vietnam. These countries are already significant as sending countries for labour migrants, with remittances as a major element of their economies. The Philippines, in particular, has a long history of sending nursing professionals overseas, until recently largely to English-speaking countries (Choy 2003). In addition to those who emigrate as nursing professionals, many who are employed as domestic workers are also engaged in childcare or care for the elderly (Parreñas 2003: 156–160; 178–182). In 2009 Indonesia and the Philippines were estimated to be in the top ten remittance-recipient economies (in dollar terms) in the Asia-Pacific region (Economic and Social Commission for Asia and the Pacific 2009: 15). Although the agreements allow for a few thousand workers to enter Japan over the next few years, it has been estimated that at least 50,000 workers would be needed to fill the current shortage in care labour (Douglass 2011: 25). Japan contrasts strongly with Taiwan, which has allowed the entry of domestic workers and care workers since the early 1990s, building on earlier programs for the entry of immigrant workers in other industries. In 2009, around half of the 340,7618 immigrant workers in Taiwan (from Indonesia, Vietnam, Thailand and the Philippines) were engaged in domestic work and care work. They are seen as 'unskilled' workers, who supplement the work of formally-qualified Taiwanese care workers and nurses (Ohno 2010: 69–83).

An economic partnership agreement between Japan and Indonesia was concluded in 2007, Japan and the Philippines in 2008, and more recently with Vietnam. For the first trainees who started work in Japan during 2009, there were reports of language problems and issues in adjusting to a different workplace environment. All of the care workers admitted so far work in hospitals and nursing facilities rather than in private care. They are expected to pass exams in three or four years in order to gain qualifications if they wish to stay on in Japan. They were provided with a six-month language course which allowed them to communicate in basic spoken Japanese, but much more specialised language training is

necessary in order to tackle the national caregiver qualifying examinations, and there have been some modifications to the Japanese-language examinations to accommodate the immigrant trainees (Kaneko 2009).

Although the JPEPA agreement with the Philippines (replacing the Philippine-Japan Treaty of Amity, Commerce and Navigation of 1973) was signed in September 2006, it took the Philippines Senate nearly two years to ratify it. There was opposition to JPEPA for, among other reasons, 'its insensitive inclusion of human labor as a commodity for exchange' (Piquero-Ballescas 2009a: 130). Besides providing a framework for liberalising trade and investment between the two countries and allowing small numbers of Filipino nurses and caregivers to work in Japan, the agreement also detailed other possible cooperative programs, including training courses for the regulation of and supervision of financial institutions, trade and investment cooperation, cooperation in the field of small and medium enterprises, technical cooperation in the field of science and communications technology and promotion of tourism. This suggests that trade benefits for Japan figured prominently in the rationale for the agreement. The nurses and caregivers are endorsed by the Philippine Overseas Employment Administration, and the Japan International Corporation of Welfare Services (JICWELS) is responsible for finding hospitals and health-care institutions in Japan willing to hire the qualified Filipino nurses (Piquero-Ballescas 2009b: 78; Agnote 2008; 'Filipino caregivers coming this year'. 2009).

At the time of writing in mid-2012, small numbers had passed the qualifying examinations as nurses and carers. Forty-seven Indonesians and Filipinos passed the nursing examinations in February 2012, a pass rate of only 11.3 per cent, but better than previous years. Thirty-six Indonesians and Filipinos passed the caregivers examination in January 2012, a pass rate of 37.9 per cent ('Foreign Pass Rate for National Nurse Exam Triples': 2012; '36 Foreign Caregivers Pass Qualifying Exam', 2012). If these small numbers of

successful examinees continue, then the majority of care workers who enter through these bilateral agreements will, in effect, be a rotating pool of short-term unskilled labour, each intake regularly replaced by a new group. Piquero-Ballescas reports that even before the finalisation of the JPEPA agreement Filipino workers were already entering Japan in order to provide care work – some as undocumented workers and some under other visa categories. Non-profit organisations (NPOs) mediate the entry of such workers; and brokers who had hitherto facilitated the entry of entertainers or marriage migrants have shifted their attention to care workers (2009a: 130–135).

In the Philippines, more than 400 nursing schools are producing more nursing graduates than can be employed by hospitals and rest homes, with many graduates pinning their hopes on finding a job overseas. For those who have been educated in English, however, other countries, such as U.S., Canada, Australia, New Zealand, and Britain may seem more accessible than Japan. The migration of nurses from the Philippines to Anglophone countries is well-established (Brush and Sochalski 2007: 37–46; Choy 2003). Doctors, nurses and care workers make strategic decisions based on remuneration and visa regimes, the possibility of transition to permanent residence in the future, and the possibility of facilitating the migration of family members.

Concern has been expressed internationally about the exodus of medical professionals from developing countries to first world countries, prompting the World Health Organisation to develop the Global Code on International Recruitment of Health Personnel (Cheng 2009, pp. 111–112). As wealthy first world countries seek personnel from around the world to care for the bodily needs of their citizens, third world countries increasingly suffer from a lack of medical professionals to meet the needs of their own populations. Some countries have strategically positioned themselves in the global labour market for health professionals: the Philippines in training nurses and care workers who will largely be

emigrants; Thailand in positioning itself as a destination for 'medical tourism' (Whittaker 2009: 319–332).

The Japanese government's attempts to deal with the crisis in care work thus have local, regional and global implications. Care work in Japan is now provided by a combination of family-based care, volunteers and paid labour. The distinction between family-based care and institutional care, however, is complex. Paid workers may assist in the family home, or family members may provide various forms of care such as providing food or laundering clothes for relatives in hospitals or institutions. Work may be carried out by Japanese nationals or by documented or undocumented immigrant labour. In practice the care work provided under the agreements with Indonesia, the Philippines and Vietnam is for the provision of care within institutions.

Care work has shifted from largely invisible work carried out by family members on an unpaid basis, to a combination of family-based care and assistance by volunteers, with marketisation facilitated by the Carers' Insurance Law. The market in caring labour is now a transnational one, involving both documented and undocumented migrant labour. Each stage in this process builds on, reproduces and in some cases transforms constructions of gender, class and ethnicity in sending and receiving countries. In Singapore, for example, Philippine women are associated with domestic work. In Japan, until recently, representations of Philippine women operated according to a dichotomy between a sexualised identity associated with the 'entertainment' industry and a domestic identity associated with international marriage (Mackie 1998: 45–63; Mackie 2000: unpaginated; Nakamatsu 2005: 405–417). As increasing numbers of Philippine immigrants engage in care work, this can be expected to contribute to an evolving picture of Philippine ethnicity in Japanese society, building on earlier cultural representations. Indeed, Lopez (2012: 252–268) argues that this reformulation is already taking place. In the case of Indonesian and

Vietnamese workers, there is not such a well-established cultural repertoire of representations, although immediate responses are likely to draw on longstanding imagery of people from other parts of Asia as 'other' to those of Japanese ethnicity.

Conclusions

While other countries are also dealing with issues related to aged care, the aging of the population is most advanced in the case of Japan – which until recently had the world's highest life expectancy and the largest percentage of the population over 65 (Statistical Bureau, Japan 2011: 16). To trace the circuits of labour mobility in the Asia-Pacific region is also to map the patterns of economic inequality in the region. Globalisation prompts us to consider biopolitics on a regional and global scale, transcending the scale of the nation-state. The management of labour power, the management of populations and the management of care for the bodies of individuals also need to be considered in a transnational frame. Individual workers cross borders to take care of the bodies of others in nursing, caregiving or domestic labour, while nation-states attempt to regulate these flows through border controls (Mackie 2010: 71–85). National governments like Japan struggle to manage a labour market which is stratified and segmented according to gender, class, caste, ethnicity and nationality. Indeed, this segmentation is in part attributable to the *ad hoc* decisions on recruiting labour power through specific bilateral agreements.

Policy decisions taken at the national level, then, build on, reproduce and transform inequalities at a local, regional and global level. Japanese government policies interact with those of other governments in the region. Local gender orders and class systems determine which workers from such countries as Indonesia, the Philippines or Vietnam will work overseas. Choices about destinations are determined by information about the labour markets and border control regimes of receiving countries. These movements are facilitated

by local education systems which develop new training programs in care work, nursing, or the languages of destination countries. Such policies also have a role in producing difference at a local, regional and global level, as labour migrants become associated with particular cultural constructions of their ethnicity in host countries (Mackie 1998: 45-63; Benedicto 2009: 289–301; Tsuda 2003: 289–305.). In the twenty-first century, care work needs to be understood as transnational biopolitics, where individual, embodied transactions between care workers and their clients are embedded in local, regional and global orders of inequality and difference.

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[2] On the gendering of care work in Japan, see Yahara's study of male care workers, childcare workers and nurses (2010: 343–356).