

# Immigrant Health Issue in Japan — The Global Contexts and a Local Response to the Issue —

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## 【Abstract】

This paper attempts to illustrate for future research how globalization affects the health of immigrants in Japan by analyzing the global contexts of Japanese immigration and a local NGO's response to the immigrant health issue. The Labonte and Torgerson (2005) Global Health Framework is used to structure the analysis and contextualize the issues and the responses within global health.

The context of immigration in Japan has produced a vulnerable immigrant population that experiences difficulty in accessing health care due to language barriers, discrimination and lack of health insurance. The Japanese government's response has focused on tightening immigration controls rather than addressing the health and human rights of immigrants. Local grassroots movements have risen to fill the gaps in government health services. One of these local movements, the SHARE immigrant health promotion program, started with a flexible program framework. A lack of well-planned strategies caused initial difficulties, however, a sustainable program developed by focusing on the fundamental values of the social determinants of health and the flexibility to adjust to changing needs. The broader political and economic context has posed ethical dilemmas for the program staff. The issues they face include health ethics and immigration authority; lack of cultural competence; access to health care and financial burden; and frustration in meeting needs and understanding the political and economic forces contributing to health inequity.

SHARE's initiative led to multiple responses by and of the community, and when situated in the Global Health Framework, these responses could be seen as contributing towards larger coordinated action that addresses systemic issues at the higher level. Recognizing local action at the community level alone is not sufficient to address the immigrant health issue in Japan; future research is needed to support coordinated community action at the higher levels for healthy public policy in immigration.

**Keywords** : immigrant health, global health, access to health care, health promotion

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## I . Introduction

Immigrants are one of the most vulnerable populations, who often fall between the cracks of social networks and health care services in many settings worldwide (Nygren-Krug, 2003). The context of immigration in Japan, with no exception, has produced an increasingly vulnerable immigrant population that experiences difficulty in accessing health care due in large part to language barriers, discrimination and having no health insurance (Hayakawa, 2005). Immigrant health concerns are evident at individual and public health levels. In comparison with the general population, the individual health outcomes of immigrants are worse because of untimely access to health care. For example, the incidence of tuberculosis is higher among immigrants than the general public due to poorer access to treatment (Sawada, 2005b). The Japanese government's response to immigration issues has been focused on tightening immigration controls rather than addressing the health and human rights of immigrants.

Due to Japan's booming economy in the 1980s, there was a marked influx of immigrant workers. As a result, local grassroots movements arose for the well-being of marginalized immigrants endeavouring to fill the gaps in government social and health services. The movements led to the creation of numerous local non-governmental organizations (NGOs), thus increasing programs and services. An example of such an NGO is Services for the Health in Asian & African Regions known as SHARE (SHARE, 2010). SHARE initially focused on the health of people in the developing countries of Asia and Africa. In 1991, after critically reflecting the values underlying their activities abroad in relation to domestic needs of immigrant health, SHARE started free medical consultations for immigrants in Tokyo (Sawada, 2005a; Yamaguchi, 2005). These consultations subsequently developed into an immigrant health promotion program, which collaborates with community partners and local governments.

This paper explores how globalization affects the health of immigrants in Japan by analysing the global contexts of Japanese immigration and the local response of the SHARE program to the immigrant health issue. The Labonte and Torgerson (2005) Global Health Framework is used to structure the analysis and contextualize the issues and responses within the global health context. The Framework identifies the differing levels and pathways that link globalization to health in a comprehensive manner and seems the most appropriate one for this analysis among a few global health frameworks (Huynen, Martens & Hilderink, 2005; Woodward, Drager, Beaglehole & Lipson, 2001).

## II . Japanese Immigration and Health

### 1. Superordinate Categories

#### 1) Pre-existing Endowments

##### (1) Economic endowments

As of 2009, Japan had the world's second largest market economy (Web Japan, 2009a) and also one of the world's highest living standards despite the country's two-decade-long economic downturn. In 2008, Japan's gross domestic product (GDP) was US\$4,909 billion, second only to the United States' US\$14,204 billion.<sup>3)</sup> Japan's per capita gross national income (GNI) was US\$38,210, which was below the United States' US\$47,580 and Canada's US\$41,730, but higher than South Korea's US\$21,530, Brazil's US\$7,350 and China's US\$2,940 (Economic Affairs Bureau, 2010). Japan's comparatively strong economy continues to be a “pull” factor for immigration, with the number of “registered” foreigners living and working in Japan rising from 1.5 million in 1998 to more than 2.2 million in 2008 (Immigration Bureau, 2009a).

However, Japan's record-high unemployment rate for the last two decades reflects the hard times of the economy. The “bursting” of the “bubble economy” in 1991 contributed to an increase of unemployment from 2.1% in 1991 to 3.4 % in 1996 and then to 5.0 % in 2001 (Kashiwazaki, 2002). Following the period of economic recovery from 2002 to 2006, the Lehman shock in 2008 abruptly reversed the economic gains (Web Japan, 2009a), leading to a sharp increase in unemployment from 3.9% in 2007 to 5.6% in July 2009 (Economic Affairs Bureau, 2010).

##### (2) Human, social and health capitals

The strong work ethic of the Japanese labour force and innovative technology were contributing factors to the high economic growth during the postwar era which enabled the country to move from “less-developed” to “developed” status (Web Japan, 2009a). As Japanese living standards increased and labour shortages grew, immigrant workers, mostly visa “overstayers” from Asian countries, filled the demands for so-called “3K jobs” (“3D” in English) – *kitsui* (demanding), *kitanai* (dirty), and *kiken* (dangerous) – that the local population avoided (Kashiwazaki, 2002; Werner, 2009). These diligent, long-term immigrant workers have become a significant human resource as skilled workers in small and medium scale manufacturing companies (Harden, 2010).

Japan has experienced migration flows from China, Korea and Taiwan from the beginning of the 1900s until World War II and a marked increase of immigrant workers since the late 1980s, nevertheless most Japanese are still conditioned to see themselves as ethnically homogeneous (Kashiwazaki & Akaha, 2006;

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<sup>3)</sup> Other key GDP comparators include China at US\$4,326 billion, Brazil at US\$1,612 billion, Canada at US\$1,400 billion, and South Korea at US\$929 billion (Economic Affairs Bureau, 2010).

Workpermit.com, 2007). Their deep conservative sense of ethnic homogeneity and cultural uniqueness makes social integration difficult for both the local and immigrant populations (French, 2003; Workpermit.com, 2007). Furthermore, poor English conversation skills among the Japanese and a lack of Japanese language skills among foreigners contribute to communication gaps between the locals and immigrants, leading to social exclusion.

Japan has a reputation as one of the safest countries with high social cohesion. In 2005, it had the second lowest crime rate of 9.9% among the OECD countries, bested only by Spain's 9.1% (OECD, 2009). Many local Japanese tend to associate "foreigners" with increased crime and social disorder (Workpermit.com, 2007) due in part to discriminatory media coverage of crimes committed by immigrants. However, since 2002, the actual number of crimes in Japan has been continuously decreasing (National Police Agency, 2010).

Japan is one of the healthiest countries in the world in terms of long life expectancy, low maternal and child mortality, and high ratios of doctors per capita. The traditional extended family support system and healthy diets are believed to be contributing factors in the excellent health of the population (Werner, 2009). In contrast, many immigrants have left countries which may have limited health care resources, high maternal and child mortality, and high prevalence of diseases such as tuberculosis and malaria (Caulford & Vali, 2006; Nygren-Krug, 2003).

### (3) Demographic profile

In 2005, Japan became the first advanced country to experience a population decrease. With a dwindling birthrate and the aging population, Japan has fewer children (13.4% in 2008) and more elderly (22.1%) as a proportion of its total population than any other country in recorded history. The working population (15-64 years old) has been declining since its peak in 1998, whereas the retired population (65 years old and over) has been continuously growing. The support ratio of the working population to the retired population has rapidly decreased to below 1.5 (only three workers for every two retirees) in 2008. This daunting demographic ratio is beginning to threaten the country's pension and health care systems. Japanese demographers estimate that the present population of 127 million will shrink to 80 million by 2060 and then to 40 million by 2110 (Harden, 2010; French 2003; National Institute of Population and Social Security Research, 2010; Workpermit.com, 2007).

In terms of immigration demographics, at the end of 2008 there were more than 2.2 million foreigners registered in Japan, comprising 1.74 % of the total population. This percentage is record-high for Japan but minuscule compared with the 12 % found in the United States. The number of illegal immigrants has decreased, mainly by deportation, from its record-high of 300,000 in 1993 to 150,000 (a 50% decrease) in 2008 and then to 91,000 at the beginning of 2010. The number is extremely small compared with 11.6 million illegal immigrants in the United States (12 times more than Japan's) whose population is 2 ½ times Japan's (Harden, 2010; Immigration Bureau, 2001, 2009a & 2010a; Workpermit.com, 2007).

Given Japan's demographic crisis and immigration profile, the United Nations (2001) projected that Japan would need 17 million immigrants by 2050 to maintain the current size of its population. By 2050, the immigrants and their descendants would comprise 17.7% of the total population. If Japan wishes to achieve a support ratio of 3.0, 94.8 million immigrants would be needed between 2005 and 2050. In this scenario, 54% of the total population would be immigrants and their descendants by 2050.

## 2) Political Systems and Processes

Despite Japan's rapid demographic aging, the national government has been reluctant to open the door to immigration. The government recently started to encourage more immigration of young, skilled workers to maintain its economic power under the global macroeconomic paradigm. Werner (2009) supports the idea of Japanese forward-thinking activists questioning the neo-liberal stance of the government. These activists argue that this over-populated island nation should explore better ways to reduce both its population and its ecological footprint to encourage environmentally sustainable healthy living.

Traditionally, Japanese businesses and their workers had strong ties to each other. The workers were very loyal to the company that, in turn, provided them with life-long employment, health coverage, benefits and pensions. This employment arrangement seemingly functioned as a protective mechanism for the workers' health, which helps explain Japan's excellent health statistics (Werner, 2009).

During the 1970s and 1980s, the majority of Japanese felt part of the middle-class and benefited from the country's remarkable economic development. This sense of a broad middle-class society was almost completely dismantled by the country's two-decade-long economic recession coupled with global macroeconomic pressures. Former Prime Minister Koizumi implemented neo-liberal forms of governance and encouraged the people to endure difficult times until the country's economy recovered. Galabuzi (2006) argued that neo-liberalism dismantles the key elements of the welfare state and social protection mechanisms. Restructuring and privatization resulted in decreased wages, increased laid-offs, the emergence of precarious work, and the breakdown of social safety nets, which led to the current unequal society of Japan. Japanese people are realizing that social inequalities are affecting their health and well-being, and are calling for immediate government action.

Due to growing apprehension about international terrorism since September 11, 2001, wariness of foreigners continues to be a dominant political force affecting Japanese immigration policies. This has resulted in a sharp increase in the number of deportations of illegal immigrants in Japan (Harden, 2010; Kashiwazaki & Akaha, 2006; Owaki, 2005). Visa overstayers, who were condoned during the worker shortages of the economic boom, are being increasingly criminalized.

Galabuzi (2006) discusses the interrelated political/economic processes of economic globalization, neo-liberalism, the emergence of precarious work and the racialization of the Canadian labour market. Japan has been going through the same processes. Kawasaki City, near Tokyo, exemplifies the racialization of the

labour market. The construction companies employed Thais and Filipinos who were inconspicuous by day and the manufacturing companies used Africans at night. Many Vietnamese work in the leather factories that used to employ Japan's own untouchables – the “eta” and “hinin.” Unfortunately, even long-term immigrants, including so-called “old-comers” who came before World War II and their descendants, still face discrimination in employment, and are treated as non-“real” Japanese (French 2003).

Precarious work has become a major characteristic of the Japanese labour market, especially affecting disadvantaged populations including immigrants. A disproportionate number of immigrants (racialized group members), especially visa overstayers, depend on undesirable “3K (3D) jobs”, which are increasingly precarious. Their work often involves long-hours, low-paid and itinerancy. As its foundering economy decreases the need for cheap foreign labour, Japan has increasingly employed aggressive enforcement of its immigration laws (Harden, 2010; Werner, 2009).

## 2. Global Policy and Economic Contexts

### 1) Macroeconomic Policies

Japan was one of the major beneficiaries of the post-World War II global economic growth under the free trade principles of the International Monetary Fund (IMF) and the General Agreement on Tariffs and Trade (GATT). Japan's swift economic growth increased its standards of living, developed its health care system and contributed to the promotion of people's health in Japan. The 1985 Plaza Accord brought about a sharp rise of the yen's value and resulted in Japan's emergence as a major player in managing the international monetary system. This was followed by its infamous “bubble economy” (Web Japan, 2009).

### 2) Global Migration and Flow of Remittances

Goto (2007) discusses the “push” and “pull” factors behind the dramatic increase in the number of unskilled foreign workers migrated to Japan after the middle of the 1980s. The influx of the Nikkeijin (Japanese origin) workers from Latin America, mostly Brazil, resulted from the revision of the Japanese Immigration Law in 1990, which will be discussed in the section on Domestic Public Policy Contexts.

As to the increase in the illegal immigrant workers from neighbouring Asian countries, one of the most important “push” factors was the decrease in the demand for Asian immigrant workers in the Middle East. The sharp increase of the crude oil price after the Oil Crisis in 1973 led to a construction boom in the oil-rich countries that recruited a large number of temporary immigrant workers from southern Europe and Asia. The number of Asian immigrant workers in the Middle East grew from 100,000 in 1976 to 1.2 million in 1982. However, by the 1980s a decrease in the crude oil price diminished the construction boom, leading to the laid-offs of 400,000 Asian immigrant workers who returned to their home countries. This was a serious blow to the economy of these Asian countries that had become dependent on the remittances from the immigrant

workers as an important source of foreign exchange. When this large pool of unemployed Asian workers eagerly sought new employment in other countries, Japan was achieving astounding economic growth with increasing domestic labour shortages.

Japan's increased labour demand in the construction industry during the economic boom had been largely filled by "dekasegi" workers – seasonal domestic marginal workers – mostly from the then-poor farming communities in the northern part of Japan until the 1980s (Goto, 2007). The "dekasegi" workers came to cities such as Tokyo and Osaka to fill temporary jobs during the farming off-season in order to supplement their unstable farming incomes. However, the number of "dekasegi" workers decreased as job opportunities in their hometowns increased. This decrease in domestic marginal workers created a serious labour shortage in the Japanese construction industry from the late 1980s, which attracted the large pool of unemployed Asian immigrant workers. The "push" factors in Asian countries coincided with the "pull" factors in Japan in the 1980s to create the influx of Asian immigrant workers to Japan (Goto, 2007).

The involvement of criminal gangs has been reported with illegal brokers' activities between Japanese employers and Asian immigrants. The Japanese Ministry of Justice (as cited in Goto, 2007) estimated that 70 % of illegal immigrant workers entered Japan with the help of such illegal brokers in 1990.

The flow of remittances from developed countries forms a significant source of foreign currency for many developing countries (Labonte & Torgerson, 2005). Brazilian "Nikkeijin" (Japanese origin) workers in Japan remitted an estimated US\$2 billion annually, nearly equal to the annual exports from Brazil to Japan (Beltrão & Sonoe, 2006, as cited in Goto, 2007). In an affluent area near São Paulo City, none of the residents depend on remittances, whereas, in a less affluent area in Brazil, 10.7% of the people entirely depend on remittances and 39.3% partially depend on them. The recipients of remittances from Japan comprise 33.3% in the affluent areas and 67.9% in the less affluent areas (Ishi, 2009).

### 3) Trade Agreements

As Japan's Economic Partnership Agreements with Indonesia and the Philippines on the acceptance of nurses and support care workers took effect in 2008 respectively, Japan received 370 Indonesian and Filipino nurses as candidates for registered nurses in Japan. These candidates require a 6-month training in Japanese language and nursing and then work in an internship with a stipend as nurse candidates in health care facilities. They need to pass the national nursing examination within three years of their arrival in Japan in order to renew their special immigrant visas (Japan International Cooperation of Welfare Services, 2010; Ministry of Health, Labour and Welfare of Japan, 2009).

### 3. Domestic Public Policy Contexts

#### 1) Immigration Policies

The basic framework for the Japanese immigration policies is the Immigration Control Act, which was originally enacted in 1952 modeled after the United States' system. From its inception, the Act was not designed to encourage foreigners to immigrate to Japan or immigrants to settle in Japan. Rather it was intended to monitor and control immigrants. The first significant shift in policy was the admission of Indochinese refugees beginning in the late 1970s, which contradicted Japan's official policy of refusing foreigners for resettlement. In 1981, Japan ratified the 1951 Convention and 1967 Protocol Relating to the Status of Refugees (Kashiwazaki & Akaha, 2006).

The second shift in Japanese immigration policy was the 1990 revision of the Immigration Control Act in response to growing migration to Japan and the sharp increase in visa overstayers. The Act was revised to facilitate the immigration of professional and skilled workers, confirming the basic principle of not accepting unskilled foreign labour. However, de facto unskilled labour migration was available through a new visa category called "long term resident." The revision of the Act allowed "Nikkeijin" (descendants of Japanese emigrants) to apply for this long-term resident visa with no restriction of employment. This new visa category was created in response to the strong request from the business sector for unskilled foreign workers during the time of the bubble economy. As a result, an influx of Nikkeijin workers from Latin America, mostly from Brazil, occurred (Goto, 2007; Kashiwazaki & Akaha, 2006).

The third shift came after September 11, 2001, in response to the growing concerns about national security and international terrorism. In 2003, the immigration authorities officially started the aggressive enforcement of immigration control with a new "policy for halving the number of illegal immigrants in five years" (Asian People's Friendship Society, 2010; Yoshinari, 2005). The estimated 220,000 illegal immigrants in 2003 were slashed mostly by deportation to 150,000 in 2008. The number was further reduced to 91,000 at the beginning of 2010 (Immigration Bureau, 2004 & 2010a). This aggressive enforcement has significantly affected the wellbeing and health of the long-term illegal immigrant workers and their families. The illegal immigrant workers try to stay away from the public except in the workplace for fear of being caught by the police or immigration authorities (Owaki, 2005).

The Japanese nationality law is based on *jus sanguinis* or "right of blood," therefore children of immigrants cannot acquire citizenship by birth. While legal immigrants and their children can acquire citizenship by naturalization, children of long-term illegal immigrants cannot have residence status let alone citizenship unless special permits are granted. "Special permits for residence" were granted to 8,500 illegal immigrants in 2009, approximately 65% of whom are those who had married to a Japanese citizen (Harden, 2010). There have been growing calls for the relaxation of immigration control to increase special permission for residence (Asian People's Friendship Society, 2010).



The fourth shift in immigration policy was the 2009 revision of the Immigration Control Act in response to conflicting pressures: aging population with dwindling birthrate, potential labour shortages, foundering economy, apprehensions about public security and international terrorism (Kashiwazaki & Akaha, 2006), and the criticisms against the immigration systems and its operations. The Alien Registration System was discontinued in 2012 and replaced with a new “System of Residence Management.” Residence Cards are issued to “newcomer” immigrants to improve and facilitate services to immigrants as well as immigration control. Special Permanent Resident Certificates with minimum personal information are issued to “old-comers.” The required personal information on the new certificates has been significantly reduced compared to the previous Alien Registration Certificates (Immigration Bureau, 2009b). Also, the revision aims to improve the refugee recognition system and services for refugee claimants, which was criticized as unjust and inhumane (RAFIQ, 2008). However, the Japanese government’s basic principles of immigration remain the same – not accepting unskilled workers and not facilitating immigrants’ acquisition of citizenship, which are apparent in the Fourth Basic Plan for Immigration Control (Immigration Bureau, 2010b).

## 2) Labour Policies

Japan's immigration policies have influenced its labour policies. The Ministry of Health, Labour and Welfare (2008) presents the basic principles of labour policy for immigrant workers:

- The immigration of professional and skilled foreign workers should be actively promoted in order to strengthen Japan’s global competitiveness.
- Working conditions and employment for immigrants should be enhanced.
- The immigration of unskilled workers should not be promoted because this may accelerate the racialized segmentation of the labour market and pose a potential threat to the improvement of working conditions. In order to address the potential labour shortages, it is primary to enhance the employment of Japanese youth, women, elderly and people with disability.

Along with these labour policies related to the immigrant workers, the Japanese government established immigrant employment centres offering free Japanese language training and classes on social integration. Then, paradoxically, the government started the controversial “Allowance for Voluntary Return” program which pays US\$3,000 to each unemployed Nikkeijin worker and US\$2,000 to each family member to return to their home country in order to address their high unemployment rate. While the allowance would be beneficial for younger or close-to-retirement Nikkeijin who plan to return, the settlers have felt unwanted and segregated by the Japanese government since the acceptance of allowance prohibits their re-entry to Japan for three years. Although the government may have had good intentions for the allowance program, it was perceived as discriminatory, exploitative and insensitive (Harden, 2010; Ishi, 2009?; Masters, 2009).

### 3) Health Care Policies

In 1961 amendments to the Health Insurance Law entitled all Japanese citizens and registered foreign residents to universal health care with one of six health insurance plans (Web Japan, 2009b). The two major plans among them are the employees' health insurance for private-sector employees and the National Health Insurance for the self-employed, unemployed, retirees and others ineligible for the employees' health insurance. The four other plans are for seamen, national public-service employees, local public-service employees, and private-school teachers and employees. This universal health insurance system covers medical, dental and pharmaceutical care without a waiting period of entitlement. Members pay insurance premiums while the employers contribute co-payments for their full-time employees. The insurance system also employs the "user fees," with members paying 10-30% of their health care expenses. The National Health Insurance covers health care up to three months retrospective to enrolment. The government eases the financial burden of the severely ill and their families through the Relief System for High Medical Care Expenses and the Disease-Specific (so-called Incurable Diseases) Medical Care Subsidies. Also, user fees are waived for people on social assistance.

Japan's social security and welfare systems lack restrictive eligibility clauses related to residence status (Nakamura, 2003) presumably because of Japan's long-cherished sense of homogeneous nationality. Foreigners without residence status used to be eligible for social assistance and health insurance. However, in 1990, the government started to tighten the eligibility for immigrants due to the decrease in welfare budgets and the sharp increase of foreign workers with no residence status. Currently, immigrants with visas of a year and longer are entitled to the National Health Insurance whereas foreign residents with short-term visas and visa-overstayers are not (Fukuda, 1996). However, many long-term immigrants in Japan who are otherwise entitled to the National Health Insurance remain uninsured due to language barriers, lack of knowledge about Japan's health care system and the economic burdens of insurance premiums (Nakamura, 2003).

## III. SHARE Immigrant Health Promotion Program

### 1. Community Contexts

#### 1) SHARE: Organizational Contexts

SHARE (Services for the Health in Asian & African Regions) is a Japanese NGO, which was founded in 1983 as a division of health care professionals within another NGO, the Japan International Volunteer Centre (JVC). When JVC started its activities in the Indochinese refugee camps along the Thai boarder in 1980, many enthusiastic health care professionals naturally participated in the JVC activities to promote the health of the refugees. Although SHARE focuses on international health, it has been deeply concerned about the health inequalities within Japan since its foundation. In 1984, it started to provide health services to one of

the most marginalized Japanese population – the homeless people in San'ya, Tokyo. SHARE became independent from JVC in 1990 after developing its organizational capacity through two collaborative projects with JVC in Ethiopia and Cambodia. Currently, it has three international community health projects in Thailand, Cambodia and East Timor, and an immigrant health promotion program in and around Tokyo, Japan.

In its mission statement, SHARE states its goal is “to achieve a fairer and healthier world through SHARING and working with people” (SHARE, 2010). It has a great passion for primary health care and advocates for health for all as a fundamental human right. The central value underlying its activities is social justice and equity. SHARE believes in empowerment and community participation, which are key features of health promotion.

SHARE members developed knowledge and skills in health promotion, especially using the community participatory approach through their experiential learning about the social determinants of health in developing countries. Towards the end of Japan's bubble economy, as members noticed increasing numbers of foreign workers in the 3K (3D) jobs in and around Tokyo, they heard increasing media reports about health inequalities experienced by those workers and their families. In 1990, some SHARE members were inspired by immigrant health programs of the “Kalabaw no Kai” and the “Kotobuki Medical Team” in Yokohama where many Filipinos worked in the construction industry. In 1991, SHARE members volunteered to try out monthly free immigrant health consultations at SHARE's office in downtown Tokyo (Sawada, 2005). The Immigrant Health Promotion Program was small and rough to start, however, with perseverance and reflexivity it gradually expanded to a sustainable and successful program. It was started out of their sense of mission to transfer what they had learned from the marginalized people in developing countries to the people in Japan. Their critical thinking and political agency to reduce health inequalities were the driving force of the program.

## 2) Program Features

The objective of the Immigrant Health Promotion Program is to “establish a support system for migrants who face difficulty in accessing healthcare” (SHARE, 2010). From the program documents (SHARE 2005 & 2010), the following four pillars of the program can be identified: 1) health service provision, 2) intersectoral collaboration and partnerships, 3) program planning and evaluation, and 4) operations research and knowledge transfer.

### (1) Health service provision

SHARE provides outreach immigrant health clinics in Tokyo and its neighbouring cities in collaboration with other NGOs, health care facilities, local governments and embassies. The SHARE members for this program are exclusively volunteers. Members include medical doctors (internal medicines, paediatricians, orthopaedic surgeons and gynaecologists), nurses, dentists, dental hygienists, dieticians, interpreters, students

and general persons. Some of the volunteers are foreign-educated health care professionals who are studying in Japan.

The outreach health clinics cover health examinations (blood pressure measurements, urine tests, blood tests, chest X-rays), medical and dental consultations, nutritional counselling, health education, oral health education, and referrals. The clinics use a multidisciplinary, holistic approach and focus on the social determinants of health. Clinical coordinators ensure a smooth flow of clients while facilitating internal referrals such as musculoskeletal examination, diabetic nutritional counselling, gynaecology consultation and health education regarding healthy lifestyle. Clients receive health reports written in their language within 3-4 weeks by mail. The report contains the results of health examinations, recommendations for healthy lifestyle, referrals to appropriate health care facilities, and requirements for further testing. The core program staff follow up on the status of high risk cases. They have provided seriously-ill marginalized clients with holistic case management, networking with various sectors between Japan and their country of origin (SHARE, 2005).

The outreach health clinics have features of health screening and are focused on prevention rather than cure. Nakamura (2003) described one of Japan's public health policies favouring mass health screening, such as infant and preschooler health screening at public health centres, schools and workplaces. The idea of outreach immigrant health clinics might have been influenced by this policy and is actually based on the public health model rather than the medical model.

Besides the outreach clinics, SHARE provides free telephone health consultations in English and Japanese during office hours on weekdays. The users of this service are not only immigrants who have health concerns, but also Japanese health care workers inquiring about appropriate immigrant health care and Japanese people inquiring about health services in developing countries (SHARE, 2010).

## (2) Intersectoral collaboration and partnerships

The original SHARE project of free health consultations failed after six months when the number of clients decreased to almost zero. Although SHARE advertised the project through some local community agencies, this failure was presumably due to a lack of opportunities for communities to participate. Owing to the SHARE's network with other NGOs, a NGO worker introduced SHARE to a Filipina community worker in a Catholic church, changing the destiny of the project. SHARE implemented the first successful outreach health consultation at a Philippines Festival after participating in the festival preparation meeting to discuss its plan with the Filipino community (Sawada, 2005a). Since then, SHARE has increasingly developed partnerships with immigrant communities, churches, other NGOs, local governments and embassies by a snowball effect.

SHARE emphasizes equal partnership with immigrant communities in planning, preparing, implementing and evaluating outreach immigrant health clinics. This equal partnership enables continuity of care,

sustainable effects of health promotion and community capacity building. Active participation of members of immigrant communities has been apparent especially in partnership with Catholic churches and labour unions (Nishina, 2005). Also, SHARE has build partnerships with many other NGOs, such as the “Minato-machi Clinic,” “Kalabaw no Kai,” “Asian People’s Friendship Society,” “Friends” (human rights group), “MIC Kanagawa” (a medical interpreter service NGO), and “GENKI” (a health service NGO). SHARE also cooperated with the Embassies of Thailand and the Philippines in implementing their health consultation programs for Thais and Filipinos in Japan (SHARE, 2005).

While there were increasing cases of tuberculosis (TB) in Kanagawa Prefecture, the local public health units had difficulty reaching the immigrant populations for TB screening. Few immigrants came for TB screening at public health centres on weekdays despite the health units’ efforts in sending out invitation cards in Japanese. On the other hand, many clients requested a chest X-ray for tuberculosis at the outreach immigrant health clinics where the X-ray facility was not available. This situation created the opportunity of building a partnership between SHARE and the government sector. The local public health units provided free X-rays at the outreach immigrant health clinics, leading to an increase in the number of clients to more than 100 in each clinic (Sawada, 2005a).

In collaboration with the Tokyo Anti-Tuberculosis Association, SHARE recruits and train interpreters and coordinates interpreter services for the public health TB program in Tokyo. SHARE dispatches an interpreter to a public health nurse’s consultation with a migrant TB client at home or at a public health centre. Interpreters provide clients not only with medical interpretation but also with emotional and cultural supports. There were 32 interpreters speaking 10 languages registered with the Tokyo Prefecture government in 2008 (SHARE, 2010).

Drawing on its long-term experience in health projects in Thailand, SHARE has a program to address the issue of HIV/AIDS among the Thai community in Japan. In partnerships with various NGOs in Japan and Thailand, the Embassy of Thailand, health care institutions and universities, SHARE provides consultations, health education, interpreter services, training of health volunteers, referrals and research (SHARE, 2010).

### (3) Program planning and evaluation

The original program started small within a flexible program framework. It was value-driven rather than strategic-driven. It faced difficulty at the beginning because of a lack of well-planned strategies; however, it successfully developed into a sustainable program by a snowball effect because of the compelling value underlying the program and adjustment to changing needs.

The staff has monthly meetings for program planning and evaluation. They constantly monitor the process and results of activities quantitatively and qualitatively. The staff evaluates the results and adjust program planning as needed. Staff use reflective practice at the personal and organizational level for program development. Their flexibility enables them to be innovative and the fundamental value enables them to stay

focused on the social determinants of health.

SHARE published its 10-year program report in 2005 based on its internal evaluation. Almost all of the core program members, partners and stakeholders wrote reflective reviews from their perspectives. The report is comprehensive, multidisciplinary, intuitive and sensitive, and reflects the true voices of all participants. Including the voices of clients who attended the clinics could further strengthen the report.

Based on the characteristics of their enterprise, the program staff and stakeholders can be considered a community of practice. A community of practice is a group of individuals who engage in the pursuit of shared enterprises together (Wenger, 1998). People who work together naturally form a community and develop a collective learning through mutual engagement. A community of practice evolves in accordance with the social energy of its members' learning process to improve their social practice. Unlike formal organizations with rigid structures and schedules, a community of practice involves flexibility, tacitness, implicitness, intuition, sensitivities and shared worldviews, which are crucial to the success of their program.

Communities of practice share common characteristics with empowerment evaluation (Fetterman, 2002). In forming a community of practice, it is innate that an informal empowerment evaluation approach is applied to the planning and evaluation of the immigrant health promotion program. Empowerment evaluation focuses on increasing awareness about the complex social issues that the program addresses. SHARE could employ the empowerment evaluation approach formally and systematically to further improve the program. The participation of the clients in the empowerment evaluation significantly benefits the program.

#### (4) Operations research and knowledge transfer

SHARE does not have a specialized researcher, however, many health care professionals volunteering in the immigrant health promotion program have become specialized in immigrant health through their practice and research activities. Their research activities have evolved out of their enthusiasm to improve immigrant health and to transfer their knowledge to others for advocacy. They have done numerous presentations at academic conferences and have published many articles in academic journals and several books on immigrant health. They have also held seminars, lectures and symposia on immigrant health to increase awareness among health care professionals and the general public. The results of their research activities and feedback from seminars, lectures and symposia have been effectively utilized in program planning.

Their program planning and evaluation can be characterized by operations research. The main tool used is statistics. They collect demographic and clinical data, and critically analyze and interpret them. The statistical analysis is then applied to their on-going program planning. Another important approach used in operations research is reflective practice, which Schön (1983), Moon (1999, as cited in Boutilier & Mason, 2007) and others have discussed. Focusing on problem solving to improve the program, they continuously analyze a complex situation using a repertoire of experiences to reframe the problem and thoughtfully

experiment with a new strategy. Their reflective practice at the personal and organizational level has developed their collective tacit knowledge of problem solving and has also contributed to personal and organizational development.

### 3) Challenges

#### (1) Ethical issues

SHARE recruits volunteers for the outreach immigrant health clinics only by referrals. It does not publicize its recruitment because of the sensitive issues around the status of immigrants who attend the clinics. SHARE provides new volunteers with pre-training about ethical issues related to immigrant health. Due to this limitation in volunteer recruitment, it is challenging to secure enough volunteers for each clinic (SHARE, 2005).

Since the Japanese government started aggressive enforcement of the immigration control laws in 2003, the number of clients attending the outreach immigrant health clinics has been decreasing. Although SHARE and the stakeholders are very sensitive about how they advertise the clinics, undocumented immigrants avoid going outside unless absolutely necessary in fear of being detained by the police (Owaki, 2005a). Health is a fundamental human right regardless of the immigrant's status. Immigrants have poor access to health care in the first place and should not be further disfranchised. It would be a violation of human rights if the immigration control were to take advantage of immigrants accessing health care. It is imperative to achieve an agreement with the immigration bureau so that the immigration laws are not enforced during the access of health care.

The health care professionals' duty of confidentiality overrides their obligation to report illegal immigrants to the immigration office (Nakamura, 2003). There were cases where doctors in government hospitals refused to provide care to illegal immigrants because they said they were obliged to follow the government's policies (Yamamura, 2005). They did not report to the immigration office, however, the refusal of health care provision is not acceptable practice. This resulted from the health care professionals' lack of knowledge about immigrant health ethics. SHARE can play a central role in providing training on immigrant health ethics to other health care professionals.

#### (2) Power dynamics

Although the relationship between health care professionals and immigrant clients is centred on trust, the disadvantaged status of immigrants can lead to perceived or real power imbalances between them. True client autonomy may be challenged where such power imbalances exist (Pinto & Upshur, 2009). SHARE is striving for autonomy for immigrants and is very sensitive about power dynamics among all stakeholders including clients. Their reflective practice helps them stay aware of their power dynamics, leading to mutual respect.

### (3) Cultural competence

The cultural competence of health care professionals in general is not well developed in Japan, due in large part to having had few opportunities to be exposed to immigrant health. SHARE members are culturally competent because of their previous experiential learning and ongoing reflective practice. Thus, in the area of cultural competence, SHARE can also spearhead awareness and capacity among health care professionals in general. Increasing numbers of hospitals and clinics are culturally competent enough to accept foreigners regardless of their immigrant status. Those hospitals and clinics accept disproportionate numbers of immigrants as recommendations spread by word-of-mouth. SHARE may expand its partnerships with hospitals and provide hospital staff with training on immigrant health to increase their cultural competence.

## 2. Household Contexts

Some immigrant communities in Japan are mature and have settled down to have families. This trend is apparent in the statistics of the SHARE outreach immigrant health clinics. The average age of the immigrants attending the clinics increased from 34 years old in 1995 to 38 in 2004. Children under 10 years old comprised less than 1% until 1997, and increased to 3% by 2001 and thereafter. The population of 20-year-olds is decreasing and that of 40-year-olds is increasing. The proportion of long-term residents (more than 10 years) increased to 32.5% in 2004. However, approximately 70% of them do not have the National Health Insurance or employees' health insurance (Owaki, 2005b).

Many immigrants have medical histories of hypertension, diabetes, liver disease, hyperlipidemia, and peptic ulcers. These so-called lifestyle diseases are often related to socioeconomic factors. Tuberculosis is also prevalent among them. Many of them suffer from headaches, fatigue, insomnia and vertigo, presumably caused by stressful living environments. Other major complaints are backache and shoulder stiffness linked to prolonged manual labour as 52% of the clients are engaged in the manufacturing and construction industries (Owaki, 2005b).

Language is the main barrier for immigrants accessing health care. Although excellent medical interpreter services are available, the health sector only requests an interpreter in high-risk cases. Therefore, language barriers continue to inhibit immigrants with minor or moderate symptoms from accessing health care. The current interpreter services are volunteer-based and do not have the capacity to respond to all the health issues of immigrants. An interpreter system for all health promotion activities would be ideal but is a financial challenge. Interpreters provide not only interpretation but also culturally appropriate emotional supports (Kim, 2009) and their actual title is "support worker," not "interpreter." There is a risk of interpreters carrying too many concerns about clients to continue working (Hayakawa, 2005) and it is imperative to establish a support system to prevent vicarious trauma.

Another significant barrier to accessing health care is the financial burden of costs, especially for undocumented immigrants with no health coverage (Sawada, 2005a). Fearing being reported to the



immigration authorities, undocumented immigrants often avoid seeking medical attention even when their health conditions are severe. When their conditions reach the life-threatening state, they are taken to hospital with additional worries about high medical costs. Hospital social workers, doctors and NGO workers make tireless efforts to explore ways to reduce the financial burdens on immigrants through available subsidized health care plans. Many immigrants have successfully received such subsidies whereas others have been deported during the application process.

There are some subsidized health care plans, which can be granted to undocumented immigrants because eligibility does not depend on residence status (Nakamura, 2003, SHARE, 2005). A pregnant immigrant woman with no residence status, for example, may receive free obstetric care in a hospital under the Subsidized Obstetric Care Plan. The Premature Infant Medical Care Plans can also be applied to premature babies without residence status. The Tuberculosis Treatment Plans does not discriminate against undocumented immigrants because of public health concerns. Kanagawa Prefecture was the first local government to flexibly apply the Regulations for Treatment of Travellers' Illness and Deaths, which had existed in dormant state for many years, to undocumented immigrants. Kanagawa Prefecture was also the first local government to establish compensation for unpaid health care expenses to reduce the financial burden on hospitals that accept immigrant patients without health coverage.

In terms of women's health, 16.8% of immigrant women complained of menstrual abnormalities at the outreach immigrant health clinics. Stressors related to their socioeconomic status are suspected to be one of the main risk factors for menstrual abnormalities, although SHARE's research could not prove a significant relationship (Matsui, 2005). Qualitative research on immigrant women's health may reveal a correlation between socioeconomic factors and women's health. Social isolation, language barriers, lack of knowledge about the health care system, economic burdens and immigrant status combined with the sensitivities of women's health issues may place immigrant women at greater risk for poor health. Some immigrant women do not notice their pregnancies until late and others do not know what to do during their pregnancies. There are free prenatal supports available, for example, a Maternal and Child Health Handbook is given to pregnant women at public health centres. The handbook includes a free ticket for a comprehensive blood test. However, the usefulness of this handbook for immigrants is low for two reasons. First, immigrant women who cannot read Japanese cannot understand it, and second, many government workers decline to distribute it to immigrants on the incorrect assumption that they are not entitled to receive it.

Enthusiastic volunteers continue to be involved in the immigrant health promotion program. Some come and go, some go abroad to engage in international health projects, and some are inspired by the program and return to school for further education in global health (SHARE, 2005). The group of SHARE volunteers is a community of practice that evolves and disperses in accordance with the social energy of the individuals' learning process. SHARE has been expanding its network of communities of practice in immigrant health promotion through its challenging but successful volunteer system.

#### IV. Conclusion

The number of immigrants in Japan is tiny compared to the United States, but the issue of immigrant health is complex and paramount. The application of the Labonte and Torgerson Global Health Framework is useful in understanding the complex issues of immigrant health in Japan. It helps situate the issue in the global context of numerous interrelated factors. Facing various immigrant health problems at the community and household levels is challenging. Thinking about the political and economic forces of globalization is daunting. However, SHARE's initiative has led to multiple responses by and of the community, and when situated in the Global Health Framework, these responses could be seen as contributions towards a larger coordinated action that addresses systemic issues at a higher level. Recognizing local action at the community level alone is not sufficient to address the immigrant health issue in Japan; future research is needed to support coordinated community action at higher levels for healthy public policy in immigration.

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# 在日外国人の健康に関する課題 —包括的背景と地域レベルの対応—

杉江 美子 ・ 小玉 敏江

## 【要旨】

多くの在日外国人は保健医療へアクセスすることが難しく、社会的弱者となっており、行政の保健医療サービスの間隙を埋めているのは、日本の非営利団体 SHARE のような草の根団体の活動である。ラボンテ&トーガーソン（2005年）のグローバルヘルス・フレームワークを適用し、日本の移民の包括的背景と在日外国人健康問題への地域レベルの対応を分析することにより、グローバル化がどのように在日外国人の健康に影響を及ぼすかを例証した。

SHARE の事業が引き出したコミュニティーの多様な反応は、グローバルヘルス・フレームワークの中に位置付けると、制度上の問題に対処しようとする高次元の協調的社会活動に寄与していることがわかる。地域レベルの対応のみでは在日外国人健康問題を解決できないことを踏まえると、高次元の協調的社会活動を支援し、健康重視の公共政策の必要性を明らかにするためには、今後の研究が必要である。

**キーワード：**在日外国人の健康、グローバルヘルス、保健医療へのアクセス、健康推進