

**Viability and Problem of the Quasi-market Delivery System
in Long-term Care Insurance:
Lessons from the Korean and Japanese Cases**

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I. Introduction

Demographic change toward an ageing society with a low fertility rate is today becoming a significant social change affecting the political economy as well as social life in most industrialized societies. Therefore, long-term care (LTC) for the old-aged has been one of the most urgent policy challenges. It concerns the complicated health and care problems that human ageing generates and thus requires a variety of policy infrastructures in which professional human resources and facilities, which produce high costs, need to be well coordinated.

Most western welfare states have provided long-term care services as a part of tax-based social and health care services. But those countries are now facing a heavy fiscal burden as well as the problems of organizational efficiency and quality control as the demand for long-term care sharply increases. Recently two new policy trends have co-evolved to solve the problems of financial sustainability and effective care service delivery and meet this challenge.

First, as the advanced welfare states have faced the increasing costs and management problems of the various social service areas, they have begun to reform their public service delivery system into a 'quasi-market system' under the assumption that it will improve efficiency and quality of services by enhancing the provider's competition and the consumer's choices in the delivery system. Even the Scandinavian countries, whose tax-based public social service system has been dominant, began to incorporate the quasi-market system into various public services such as health, social welfare, education, and **employment**.

Second, an increasing number of countries recently began to adopt an insurance form of LTC due to its nature of easy financing and cost containment. In this sense, the policy mix of the insurance form of financing and the quasi-market form of delivery system is becoming an interesting policy experiment, especially for the countries attempting to adopt the LTC policy.

Japan started long-term care insurance (LTCI) in April 2000 by abandoning an attempt to adopt a tax-based system. Following that model, Korea began to implement LTCI in July 2008. In this sense, Japan and Korea will be interesting examples of the policy mix of the insurance form of financing and the quasi-market system in service delivery.

The quasi-market theory claims that its efficiency requires the proper institutional conditions in which the providers can enter the market easily and then allow the users to choose the diverse services according to their needs. However, LTCI has by nature many institutional limits to create competition and choices.

This paper raises a question whether the policy mix of the insurance form of the financing method and the quasi-market system in service delivery will be a viable option for the long-term care of the old-aged in the future. In order to answer it, I will evaluate how the program structure of LTCI affects the basic functions of the quasi-market, the problems it inherently produces, and how Japan and Korea have tried to solve them. In the process, I will focus on whether competition and choice will sustain the effectiveness of the quasi-market or the government's regulation or governance will be a more important matter than competition and choice.

First, I will construct a quasi-market model for LTCI mainly based on Le Grand and his group, and briefly discuss some theoretical issues in relation to LTCI. Second, the developmental background and the program structures of the LTCI of Japan and Korea will be reviewed. Third, this paper will analyze how the quasi-markets in their LTCIs are working, what are their problems, and how they are solving them. Finally, I will discuss the future respects of LTCI.

II. Theory of Quasi-Market and an Analytical Framework for LTCI

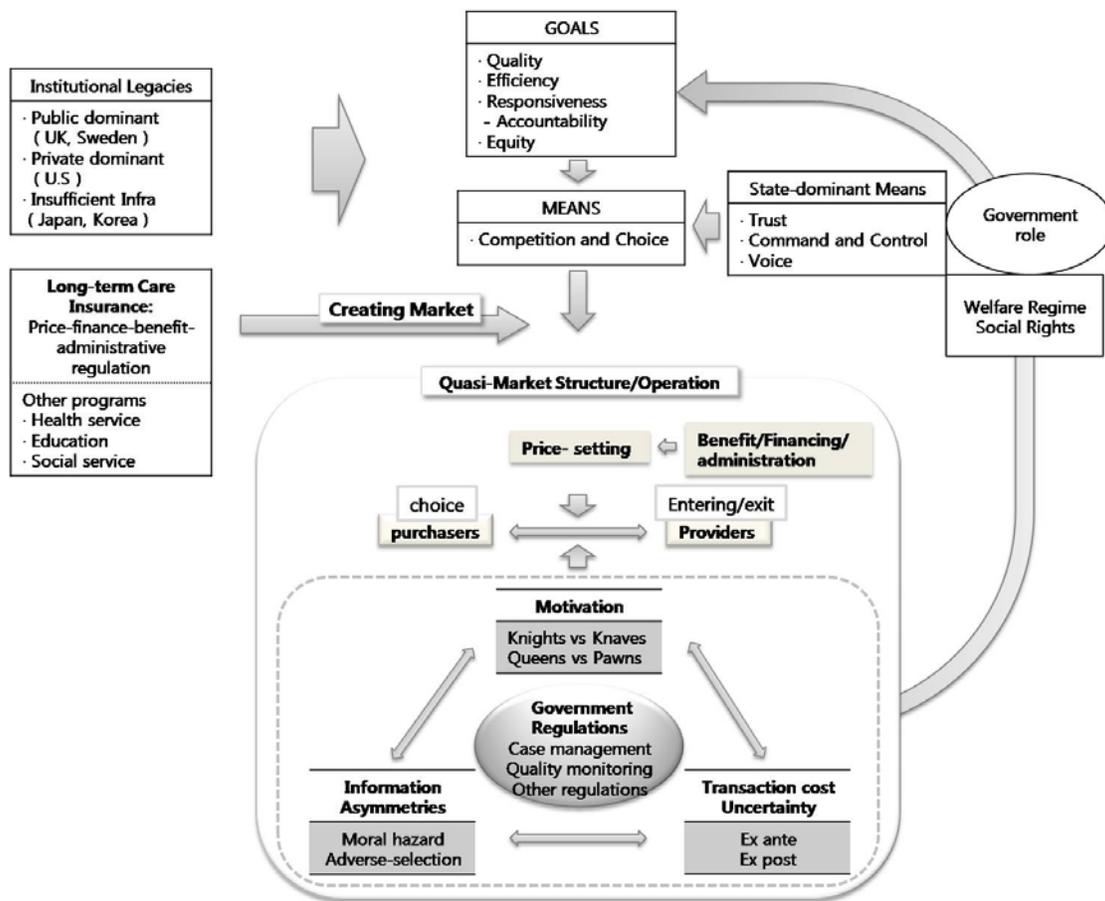
The theory of the quasi-market has been developed mainly by Le Grand and his groups (i.e. Le Grand and Bartlett, 1993; Le Grand, 2003 and 2007). A quasi-market is distinguished from a pure market by largely two characteristics.

First, the composition of the service providers is diverse from the public to private sector; public, non-profit, and profit organizations together provide their services through competitions. Therefore, their principles of organizational goals and motives of behaviors are not necessarily profit-motive driven as in the private market. These differences create imbalances and unexpected consequences in the working of the quasi-market.

Second, a quasi-market for social service is based on public funds either from tax or from the insurance fund, both of which are made available by the government. But the route

of public money to the delivery system is different; in the traditional tax-based public system, the government's funds go directly to service providers, but in the quasi-market, the public funds go to the clients or consumers. It is more like a voucher system. However, due to the limited public funding capacity and financial sustainability in the future, tight price regulations and the limited types of services are important policy means to solve them. Therefore, the working of the quasi-market could be quite different from the pure market even though the common principles of both markets are the choice and competition.

<Figure 1> An Analytical Framework of the Quasi-market for the Long-term Care Service



According to Le Grand (1993, 2003, and 2007), the quasi-market theory consists largely of three parts: goals, means, and market structure. <Figure 1> is a diagram that conceptualizes the quasi-market by showing the market structure and operating mechanism in terms of the long-term care insurance program. I will briefly explain their basic concepts and

theoretical arguments in the various public services, including LTCl.

1. Goals: Criteria for the Evaluation of the Performance

Le Grand and Bartlett suggest that the quasi-market system as an alternative to the monopoly public system seeks four goals (Le Grand and Bartlett, 1993; Le Grand, 2007). These will be the criteria for evaluating the performance of the quasi-market system.

1) Quality

The quasi-market theory ultimately aims to improve quality of services through competition among the service providers because it is assumed that the monopolist service provision in the public service system has degraded the quality of service. In order to evaluate the quality dimension of the public services, it is important to note that there are different possible definitions of the quality. Le Grand defines the quality from four different aspects: inputs, process, outputs, and outcomes (Le Grand, 2007: 7). Input can be a variety of services such as institutional care, home care, nursing, and so on, and their qualities. However, given the nature of LTCl, the types of services are already predetermined.

Nonetheless, the provider's qualities of services by each type of service will remain important criteria for the evaluation of the effectiveness of LTCl. For input quality, above all, the qualities of facilities and the competencies of professionals and service workers will be a crucial measurement for the quality evaluation. The qualities of the process aspect can be related with the actual behaviors of the service providers such as the kindness or consideration that users experience or the amount of time that they have to wait for the service. The output qualities can be measured as the number of 'activities,' or cases that are treated. The final evaluation of outcome can be measured with a result shown from use of the service such as improvements in clients' health status and the degree of rehabilitation, or the degree of satisfaction in the services. As we have seen, the long-term care services consist of various types of services and their combinations. Therefore, the measuring of the outcome is not easy, depending upon the evaluator's perspective. However, in reality inputs and outputs are preferred due to their measurability. Anyway, there is no reason why there should be only one criterion for the quality. Depending upon the characteristics of the programs, different

aspects of the quality can be used.

2) Efficiency

In fact, all public or private organizations naturally want efficiency, given the lack of organizational resources. Indeed, there are many different ideas on efficiency, from the simple economic sense to the invisible and normative x-efficiency. Among them, Le Grand and Bartlett contrast two different kinds of efficiency (1993: 14-15): crude efficiency vs. productive efficiency. The former is usually concerned with ‘the money for value.’ This is perhaps the most common criterion for the economic sense. In this interpretation, an efficient service is one that minimizes the total costs of service delivery. Nonetheless, cost-cutting has been in reality regarded as the most important regardless of the quantity or quality of the service provided. Thus, we need another criterion for efficiency to make quality not so readily sacrificed.

The alternative concept to the former one is productive efficiency. The main idea of this concept is that the services should be efficiently delivered by meeting the given goals or targets. That is, it considers the goals of the program and the normative values of the public services. This might be an ideal concept of the efficiency in terms of the public services. Providers should perform their services efficiently under the given quantity and quality of service. In reality, it is not only easy to measure, but it is also very difficult to expect in terms of the program characteristics of LTCI. It is because the government’s choice of LTCI rather than a tax-based program is mainly for reasons of cost-containment and financial sustainability of the program.

As we will see later, both countries have chosen LTCI mainly out of consideration for government revenue capacity and the program’s financial sustainability. Thus the cost of the services is usually lower than in the private market. Le Grand argues that “for efficiency service is one that delivers the highest possible quality and quantity of that service from a given level of resources” (Le Grand, 2007: 9). Perhaps when the countries whose LTC services have been delivered by the monopoly public service organizations implement the quasi-market strategy, they can compare the relative efficiency compared with previous monopoly public service systems. But in the case of Japan and Korea, both countries started LTCI without extensive public service organizations. In this sense it is not easy to measure

the efficiency gains by introducing the quasi-market in LTCI. Overall, the administrative costs of the insurance fund in comparison with the quality evaluation will be a possible measure. However, it is difficult to measure efficiencies in the various service providers in the non-profit and profit sectors.

3) Responsiveness/Accountability

This criterion came out of the problems of the bureaucratization of the public services. It is known that welfare bureaucrats and professionals have been more concerned with improving their own working conditions or increasing organizational power rather than meeting the needs and wants of their clients and citizens. The traditional administrative theory assumes that public services should respond flexibly and sensitively to the needs of their clients. Responsiveness could be a part of the service quality in terms of process. Thus, when we evaluate the responsiveness, it can be considered within the criterion of the quality.

When we think of responsibility/accountability as one of the goals of the quasi-market, the supply side of the LTCI program structure is divided into the service providers and the local government, which are responsible for financing, monitoring and regulating the providers. Thus these two different groups should be differently evaluated from the perspective of responsibility/accountability.

Advocates for the quasi-market assume that competition among the providers will enhance the responsiveness to the clients. But in reality, the competition is very limited and due to the problem of information asymmetries, the providers, even though they are competitive, can take the position of the monopoly. Therefore, responsiveness/accountability is not only a matter for the service providers, but also for the government organizations responsible for the LTCI programs.

4) Equity

The concept of equity is basically controversial because it is a very normative concept and various interpretations are possible. The concept of equity is normatively related to social justice and fairness. Overall, as a common denominator of the various concepts, it would be reasonable to assume that a good public service is one where there is broadly equal

access for all, irrelevant to their need for the service.

There is a trade-off relationship between efficiency and equity. But we should know why the long-term care is provided in the public domain rather than the private one, even though market principles are introduced into the providing services. Therefore, the providers should not discriminate in terms of social class, gender, ethnicity, and geographical area, and whatever the universal human existence. Equity concern also needs to be considered in terms of input process, output, and outcome. In relations to the equity issue, the quasi-market theory has considered cream-skimming as the most important issue

2. Means

The quasi-market theory suggests four different means for delivering services: trust, command-and-control, voice, and competition. Trust implies that the service providers (organizations, professionals and service workers) perform their jobs and missions based on the normative professional or organizational norms, and then that the clients trust their decisions and allocation rules. This is related to Le Grand's motivation theory of 'knight' vs. 'knave' and 'pawn' vs. 'queen' (Le Grand: 2003). According to this theory, it is expected that the providers behave like knights, as guards and protectors of justice and ordinary people, while clients are supposed to be 'queens,' receiving responsiveness from the people who work for the delivery organizations, whereas knaves are self-interested and work for the maximization of their own interests.

Command-and-control (or hierarchy) implies the state or the state agency engages in service delivery through a managerial hierarchy, in which senior managers give orders or instructions concerning delivery to subordinates. This is the traditional state-centered delivery system of the public services. Voice means a democratic style of delivery. A good service delivery relies on mutual communications between providers and clients in a variety of ways, from face-to-face contract with professionals through to complaints to elected representatives.

In the quasi-market, it needs to be recognized that all of the means are used together for effective and efficient delivery. It is not a matter of replacing one with the other in its entirety. In reality, virtually all systems of public service delivery use some combination of all of the models. It concerns the desirability of shifting the balance in a delivery system in the

direction of one model or another, but without completely displacing the remaining ones. The quasi-market theory argues that in order to meet these basic goals of public services, competition and choice are primary means with others.

3. Market Structure and Operational Problems

The quasi-market theory claims that three important problems should be solved for the successful working of the quasi-market: i) information asymmetries, ii) transaction costs, iii) motivation. The main reasons that the public service delivery has been favored over the market delivery have been market failures and justice issues. In the quasi-market the most serious barriers to the effective functions will be high information asymmetries and transaction costs (Le Grand and Bartlett, 1993; Barr, 2004).

In particular, the long-term care services are the ones that meet the very complicated and diverse needs of the old-aged. Therefore, information failure is indeed the most significant problem that the health and human service area should deal with. In this area, the professional providers actually determine the demand of the clients. They do not know what kind of care will be appropriate for them because the care services require some professional diagnoses. Therefore, both sides of the market (demand and supply) should be able to enjoy access to cheap and accurate information, particularly concerning the costs and the quality of the services. As we will see later, it is very difficult to create such conditions. It is a matter of sophisticated institutional design.

Second, the transaction costs in the quasi-market are also related to the information asymmetries. But the transaction costs are more concerned with the uncertainties of the transaction in the market. Therefore, transaction costs become high if the market is more competitive and transaction processes are more complicated. In this sense, the transactions which take place in the quasi-market are dependent upon the characteristics of services and the program design. Public services are often quite complex and multi-dimensional, involving the provisions of sophisticated service activities rather than the relatively basic provision of material commodities which markets deal with. Some services often have considerable uncertainty surrounding the future needs or demands for these services such as health or employment service. Williamson suggests two different types of transaction costs: *ex ant* vs. *ex post*. The LTC services consist of a variety of combination of services related to human

ageing. In the private market, the LTC services have high transaction costs. But as we will see later, the program structure of LTCI is usually designed to heavily regulate the provider's competition and the client's choice. In this sense, transaction costs could be relatively low, compared with other services.

Third, the motivation problem in the operation of the quasi-market is another important factor for its effectiveness. This is readily discussed when we explain various means to achieve the goals of public services. It is true that the effectiveness of the service delivery is largely dependent upon service agencies' value systems and rationalities for action. As we have seen above, the delivery system of LTCI is very complex, consisting of various combinations of different types of agencies and services. Therefore, there will be different combinations of motivations in the quasi-market such as providers, purchasers, and the government as a third party. Le Grand's typology of motivations such as the metaphorical knights vs. knaves and queens and pawns will be helpful in finding out the motivational problems for each agency.

Fourth, cream-skimming is the most concerning normative issue in the quasi-market because the public services are supposed to solve the equity question. It means that the nature of the quasi-market and its regulation tend to create adverse selection in various aspects of service delivery. Therefore, the program design to prevent cream-skimming is the final criterion for the successful working of the quasi-market.

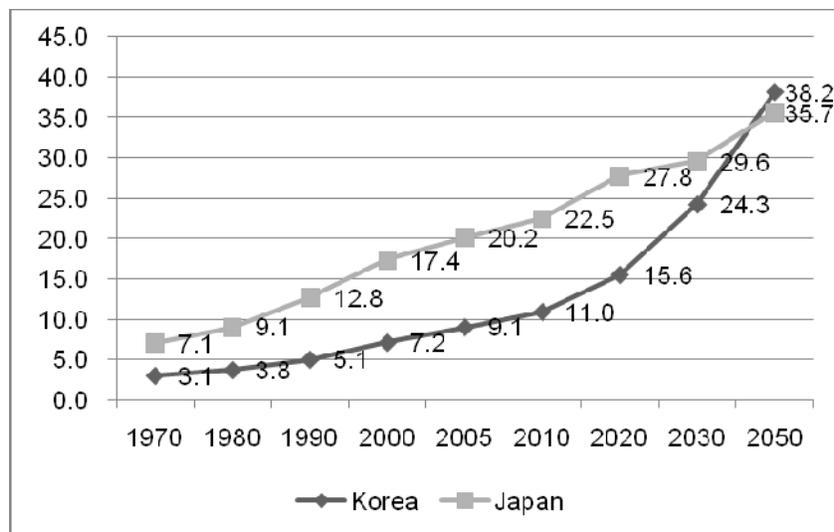
III. Background and General Overview: Japan and Korea Compared

The common background of Japan and Korea's adoption of LTCI certainly has population ageing itself at its core (Kwon, 2008; Lee, 2007; Campbell and Kiegi, 2003). Ageing society began to increase the number of old-aged persons who cannot lead a decent life without assistance. Traditional sources of care are declining. Changes in family structure mean that fewer spouses and children will be available to help. An increasing proportion of women in middle life enter the labor market for income earning. The increasing financial burden of current long-term care causes distortions and fiscal strains in programs designed for other purposes, such as medical care, social welfare, and housing. Both countries have universal health insurance programs. Japan's insurance program especially created a serious

fiscal burden due to the fact that an increasing number of the old-aged have been taken care of by the insurance system, by so-called “social admission” of patients in hospitals and health insurance.¹ Korea is now beginning to face such problems.

<Figure 2>, <Figure 3>, and <Figure 4> show the general trends of rapid old-ageing in Korea and Japan. In terms of ageing speed, Japan began to suffer from an ageing society from the 1970s, quite earlier than Korea. Korea has started now and will surpass Japan in 2050. Then Korea is expected to be the most ageing society in the world (See, <Figure 3>). The fertility rate in Korea is very impressive (See, <Figure 4>). It sharply fell in the middle of the 1980s to the Japanese rate and now is lower than that of its neighbor. Health costs in Japan are much higher than those in Korea. Japanese health insurance benefits are more generous and still virtually support the old-aged with LTCI. Korea is also expected to have a much faster increase in medical costs for the old-aged.

<Figure 2> Population trend in Korea and Japan (65+ year-old)



Source: Korea National Statistical Office, 2006. Special estimation of population.
Japan Statistical Office. 2006. Estimation of population.

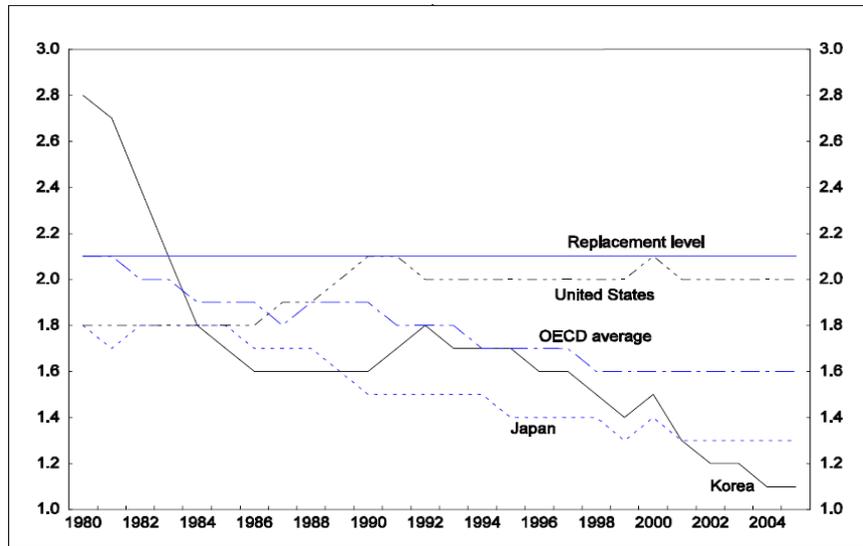
Compared with Korea, Japan has a long history of policy on old-age, beginning in the 1970s. The government responded in 1989 with the “Gold Plan”, which prepared for a vast expansion of the LTC service (primarily community-based) via grants to local governments over a ten-year period. However, the government realized that the cost of this

¹ In Japan, growing deficits in medical insurance are partly due to the fact that most institutional LTC has been provided in hospitals. Nearly half of all hospital in-patients are over 65 and about one-third of these have been hospitalized for more than one year (Campbell and Ikegami, 2004).

tax-based community care system would be very high. During the 1990s, there was a major change toward the insurance form of LTC.

Korea's ageing problem will become more serious unless the country implements some preemptory measures starting today. In this sense, Korea's policy idea for LTCI started in 1999 when the financial crisis contributed to the Kim Dae Jung government's productive welfare reform and a serious comprehensive policy design and implementation strategy were made by the Roh Moo-hyun government.² Korea's process of policy development for the old-aged has yet to mature and much more deserves to be done.

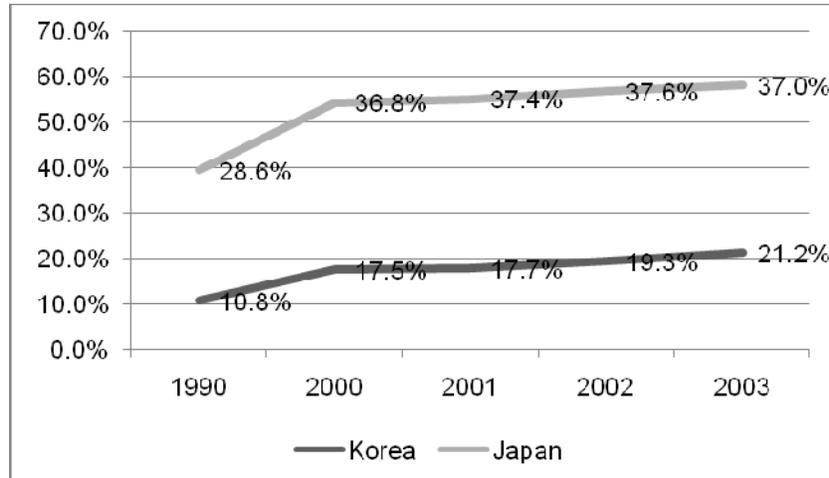
<Figure 3> Trend in total fertility rate in OECD countries, Children/women



Source: OECD, 2008

<Figure 4> Medical expenditure for the old-aged (65+), Korea and Japan

² The Roh Moo-hyun government established a special presidential committee, the Committee for the Society of Old Ageing and Low Fertility, and his comprehensive reform plan, 'Vision 2030', incorporated a variety of policy measures.



Source: Ministry of HSF (Korea), Ministry of HLW (Japan)

A Brief Comparison of the Program in Both Countries

<Table 1> Basic Schemes compared. Korea, Japan, and German

	Germany	Japan	Korea
Implementation	1995 April	2000 April	2008 July
Coverage	Old age and disability pensions, acute health care	Above 65-year old age: 1 st Category I 40-60 years old disabilities: Category II	Above 65-year old Disabilities caused by the old-aged
Financing	Insurance contribution 100% from all the insured	Insurance contribution 45% from above 65-year old, 15% from 40-64-year old, 30% Tax 45%: central gov. 22.5, local gov. 22.5%) Beneficiaries 10%	Insurance contribution: the rest Central government: 20% of the insurance revenue Beneficiaries: institutional care 20% Home care 15%
Insurance contribution burden	Employer and employee each 50% Self-employed 100% Pensioners: 50%	Employer and employee each 50% Self-employed 50% with 50% government subsidy	Employer and employee each 50% Self-employed 100%
Benefits	Institutional care Home care Cash benefit 1-3 care levels	Institutional care Home care 1-5 care levels Budget ceiling	Institutional care Home Care 1-3 care levels Cash benefit(limited to remote areas)
Administration	Health insurance	Local municipals	Health insurance corporation (central government)

As we can see in <Table 1>, LTCI programs are much similar in terms of coverage and benefits, compared with those of Germany. It is because both countries share many similar institutional legacies around the LTCI program. Korea's social security system, like Japan's, is based on a wide range of social insurance programs and the public-based infrastructure for the elderly was far less developed, compared with Japan. In other words, the institutional and demographical conditions for LTC were very similar. Japan plays a preceding role for Korea.

Coverage for the Japanese is a little wider, with two categories: category 1 covers people aged 65 and older; and category 2 covers the disabilities of those aged 40 and older. Korea has basically the same in category 1, but provides very restricted benefits to old-aged disabled people.

Financing methods for both countries are similar in basic structure: the insurance premium, government subsidies, and co-payment. But Korea relies more on the insurance premium than Japan. In Korea central government subsidizes 20% of the collection of insurance premiums. Japan's is rather complex; the component of the insurance part is 45% of the total fund, central government subsidizes 45% to the insurance fund; pension earners pay 10% from pension benefits as their premium. People aged 65 and older pay 15% of their medical insurance premium to the fund and those aged 40 to 64 pay 30% of the medical insurance premium to the fund. Contribution rates between employer and employee are each 50% of the total premium; the self-employed pay 50% of their premium with the subsidy of the government 50%. The share of the insurance premium between employers and employees is each 50% for both countries; but the self-employed in Korea pay 100% of all premium. In copayment 10% both of institutional and home care, Korea 20% for institutional care, 15% for home care. The Korean side has a greater cost-containment element.

Benefit structure is also basically similar, but Japan has a more diversified benefit structure, which allows a wide range of needs to be considered; Japan has five levels of institutional care and two levels of home care, while Korea has only three levels for both services in which levels 1 and 2 provide institutional care.

Administration of LTCI is quite different; in Japan local municipals run the program and have relatively broad autonomy on decisions of financing, benefits, and administration, while in Korea the National Health Insurance Corporation (NHIC), a quasi-public body of the

Ministry for Health, Welfare and Family Affairs (MIHWAF), runs the program.

The overall comparison of the formal program structures of both countries' LTCI reveals that the Japanese model is more generous and sophisticated than Korea's. As time passes, the Korean model is expected to become closer to its Japanese counterpart.

IV. Does the Quasi-Market Meet its Promises? The Case of Long-term Care Insurance

1. Creating a Quasi-Market with Long-term Care Insurance: Criteria for the Market Performance

As we have discussed above, the quasi-market's basic principle for its effectiveness is competition and choice and the following five requirements need to be met: i) a competitive market structure; ii) availability of all relevant information; iii) minimal transaction costs; iv) the right incentives (motivations); v) avoidance of cream-skimming. However, these conditions for the quasi-market could not easily be met not only due to the institutional setting of the long-term care insurance, but also due to the natures of those conditions themselves.

Here, we will examine how these institutional conditions at the theoretical level of the quasi-market are reflected at the practical level, what problems occur in the operation of the quasi-market in terms of its basic goals, and how both Japan and Korea tried to solve the problems of the quasi-market they created. By doing so, we will receive some important lessons in terms of the operation of the quasi-market in the real world and the future institutional design for the quasi-market.

1) Logics of the LTCI and the Importance of Institutional Legacies

Institutional logics of the insurance form of LTC itself tend to fit well to those of the quasi-market. First of all, under the LTCI, benefits are an explicit entitlement for individuals, with their eligibility decided according to objective criteria based on the extent of physical or mental disability. Therefore, income and availability of informal care need not basically be taken into account for eligibility.³ The insurance form can eliminate the complicated and stigmatizing social financial eligibility rules and the arbitrary bureaucratic decisions, which are often regarded as the tax-based system's disadvantages (Campbell and Ikegami, 2003). Given the universal entitlement based on the contribution, choice of services is in principle given to the clients with either cash or voucher types of benefits. And the adoption of the

³ There are some exceptions depending upon the countries. Korea and Japan provide eligibility to low-income people benefiting from public assistance programs. However, Japanese and Korean LTCIs are basically a universal system.

quasi-market system means that the public money basically goes to the consumers rather than the providers. Therefore, the choices for the clients increase and the ways of operations and the motivations of major agencies need to change.

The insurance form basically lets clients decide what services they want to meet their preferences (including the mix of health and social services), and also encourages competition over quality and (possibly) price. Disadvantages of the insurance form of LTC might result in the waste of resources or dead-weight cost of the covering people who could rely on their own funds or family without public support and the difficulty of monitoring the appropriateness of services.

First of all, when we evaluate the inner mechanism of the quasi-market in terms of choice and competition, we should also consider the institutional legacies of the given countries. There are two things to be considered.

First, in many cases, the choice of the insurance form of LTC is more related to each country's institutional legacies of the related programs rather than pure institutional rationalities. The main reason is that LTC requires a substantial infrastructure, which can be developed more easily from an existing system (note that both Germany and Japan rely on existing health insurance organizations to collect premiums). The countries have a social insurance system that is more likely to choose the insurance form of LTC due to the logics from the institutional compatibilities among relevant programs.

Second, the workings and developmental paths of the newly created quasi-market are also dependent upon the preexisting composition of the public, non-profit, and profit. There might be a variety of types; i) public dominant (i.e. Scandinavian countries and Britain), ii) non-profit dominant (i.e., Continental Europe, Japan), and iii) profit dominant (i.e., USA), and iv) various combinations of the three types or the overall poor infrastructure (i.e., Korea) (See, <Figure 1>).

The preexisting institutional legacies in the delivery system critically affect the strategic choices about the program structure when a country tries to newly create a quasi-market, and then the strategic choices shape the next developmental stage of the quasi-market. The recent new institutional theories, using the theoretical concept of 'path dependency,' can effectively explain the institutional barriers to the effective creation of the quasi-market and its developmental path in the later period.

For example, Britain started to adopt the quasi-market where the public service in

various areas has been dominant, while many countries with the tax-based social service delivery system (Denmark, Sweden, Netherlands, Australia, et al) have begun to adopt the quasi-market in their system. Nonetheless, the institutional structure and the motivations of the major players are still public and bureaucratic oriented. Thus, the minimum level of protection and public accountabilities can still be guaranteed due to the previously existing extensive public delivery system, and the state regulations can be quite effective when they have the problems of the quasi-market. Therefore, these institutional legacies determine the next stage of the development and problems of the quasi-market.

On the other hand, in the countries that did not develop the tax-based public system, major agencies will be either non-profit or profit and they do not have the cumulative and extensive experiences of the public service delivery. When those countries attempt to create the quasi-market as a main delivery system, the behaviors and problems that are generated in these countries will be different from those with the public dominant system. They basically lack the public mentality; instead, the crude profit mentality may increase as competition occurs. Then cream-skimming effects could increase.

Furthermore, if countries do not produce well-disciplined professional care managers and service workers and fail to provide an education and training system for professionals, those countries may endure many trials and errors and there will be a high possibility that the quasi-market system will fail.

Therefore, when we evaluate the operating mechanism and the effects of the quasi-market on the service delivery, it is important to know how the institutional legacies limit and enable the efficient functioning and changes of the current quasi-market.

2) Price-setting: How price-setting in LTCI affects Competition and Choice?

The price-setting structure will be the most critical factor of the well-functioning of the quasi-market. In the public service areas, the price-setting is not like a pure private market, in which the demand and supply primarily determines the prices.

The LTCI program basically consists of a limited number of benefits and their fixed prices. This price-setting structure constrains the entry of providers, the competition among them, and finally the user's choices. In order for the quasi-market to work well under the fixed price system, the prices should reflect the reasonable cost and returns on the part of the

provider; in other words, “fair prices” from the perspective of the providers. In the real world, however, the prices of the services are generally determined at a much lower level than those in the fair or private market. Then the low-fixed prices set by the government affect the motivation of the providers and consequently the quality of the services and the choice of the clients. The low prices motivate the providers to choose the clients most favorable for operating the business profitably. Some significant consequences are the cream-skimming (adverse selection) and the overuse of services, and even illegal trades (Le Grand, 2007).

First of all, in the long-term insurance program price setting is very restricted. Price controls are necessary in order to ensure providers are not driven out of the market. <Table 2> and <Table 3> show the comparison of prices of the selected and corresponding services in both countries. Overall, the prices in Korea are much lower than those in Japan. It is known that the prices were fairly comparable with the market prices when Japan first implemented LTCI in 2000. It might be a strategy of the government to induce the profit- and non-profit organizations to enter the service market. And the prices of institutional care are set relatively higher, compared with the prices in home care. However, as the demand for the long-term care services rapidly increased right after the program started, the government, originally concerned with the financial sustainability of the program, gradually lowered the service prices. This lowering price pattern created unbalanced entries of providers.

<Table 2> Comparison of Institutional Care Services, Korea and Japan (2008)

		Korea : level 1 Japan : level 5*	Korea : level 2 Japan : level 4	Korea : Level 3 Japan : level 3
Korea	Old-age care services	38,310Won (29.93\$)	33,660Won (26.30\$)	29,020Won (22.67\$)
	Old-age special care services	48,120Won (37.59\$)	43,550Won (34.02\$)	38,970Won (30.45\$)
	Old-age group home	48,120Won (37.59\$)	43,550Won (34.02\$)	38,970Won (30.45\$)
Japan	Old-age welfare services (previous one)	8,590Yen (86.65\$)	7,890Yen (79.59\$)	7,180Yen (72.43\$)
	Old-age health care services	9,110Yen (91.90\$)	8,580Yen (86.55\$)	8,040Yen (81.11\$)
	long-term old age services	12,110Yen (122.16\$)	11,200Yen (112.98\$)	10,190Yen (102.79\$)

*Level 1 in Korea is comparable with Level 5 in Japan.

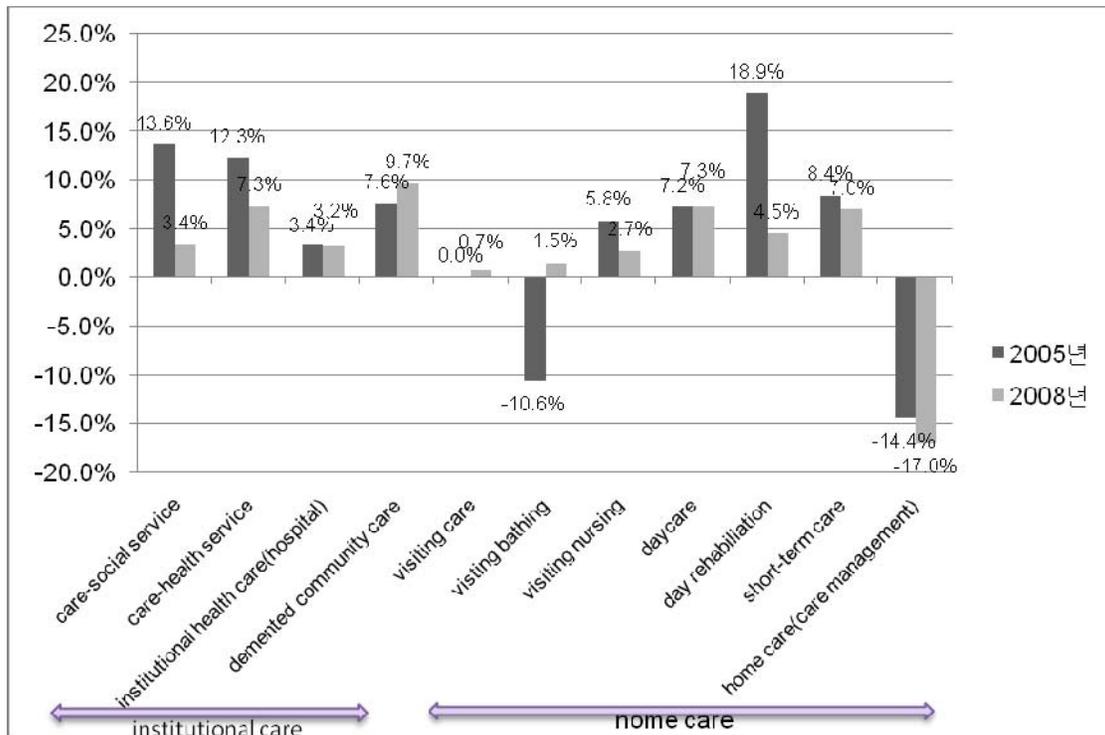
Source: NMIC in Japan and NHIC in Korea

<Table 3> Comparison of Home care

Korea	Visiting Care	30~60min	60~90min	90~120min	120~150min
		10,680Won (8.34\$)	16,120Won (12.59\$)	21,360Won (16.69\$)	26,700Won (20.86\$)
	Visiting Nursing	30min -	30~60min	60min +	
		27,360Won (21.38\$)	35,310Won (27.59\$)	43,260Won (33.80\$)	
	Visiting Bathing	care use	no care use		
		71,290Won (55.70\$)	39,590Won (30.93\$)		
Japan	Visiting Care(physical care)	30min -	30~60min	60~90min	90min +
		2,310Yen (23.30\$)	4,020Yen (40.55\$)	5,840Yen (58.91\$)	6,670Yen (67.29\$)
	Visiting Care (home keeping)	30~60min	60min +		
		2,080Yen (20.98\$)	2,910Yen (29.36\$)		
	Visiting Nursing	20min -	30min -	30~60min	60~90min
		2,850Yen (28.75\$)	4,250Yen (42.87\$)	8,300Yen (83.73\$)	11,980Yen (120.85\$)
Visiting Bathing	12,500Yen (126.10\$)				

Source: Ministry of Health, Labor, and Welfare. Surveys of the long-term care services. Annuals in Japan; NHIC in Korea

<Figure 5> Return Rates of the Long-term care services in Japan



Source: Japan: Management Performance Survey of the Long-term Care Insurance, 2008.

The return rates and the trend of the providers in entering the market reveal how the

price-setting system affects the providers' motivation and the problems in quality and equity. First of all, <Figure 5> shows the return rates of the various types of institutions and services between 2005 and 2008. The overall picture reveals that the return rates decreased over most services because the Japanese government lowered the prices of the services. The services with the worst returns were visiting bathing and care management. It is especially interesting to note that care management in home care suffered the most deficits. As we can see later, the poor performance and lesser professionalism of the care management system in Japan has been criticized.

Korea set the service prices at a much lower level than those in Japan. It has been only three months since Korea started LTCI. Thus any significant data about performance have not been produced and there are some reports on the problems in quality and equity of the providers caused by the low prices. It seems that from the Japanese experiences during the past seven years, Korea might have more serious service gaps among the regions and social classes.

Price setting and unbalanced supply of providers in Japan

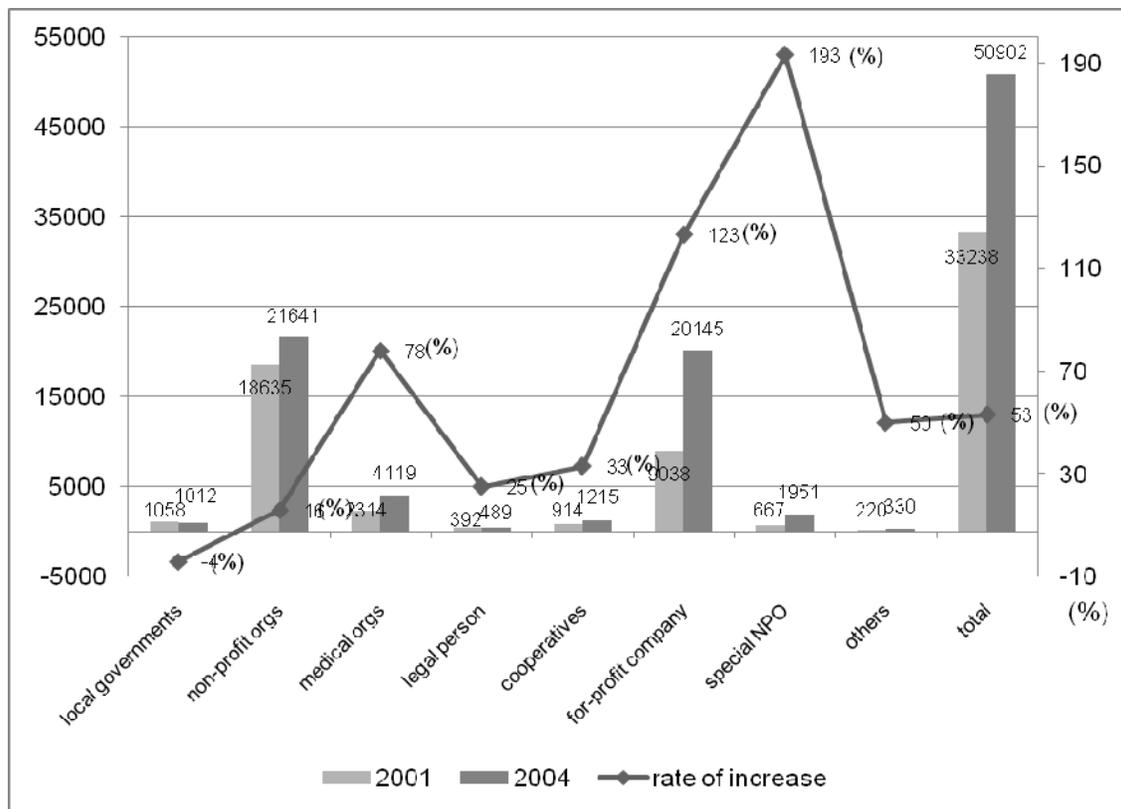
The different return rate for the providers resulted in a different supply pattern by them. As we mentioned above, the basic motives for adopting LTCI for both governments were easy financing through the health insurance system as well as easy building of service infrastructures by creating a quasi-market, especially by encouraging non-profit and profit sectors (Sawasi, 2008).

However, it is not easy to create a quite competitive quasi-market that will lead to fair choices for the consumers. There are three key different types of service organization in the delivery system in terms of ownership: public, non-profit voluntary, and commercial/profit organizations. These different organizations have different motivation structures. Therefore, these organizations enter the quasi-market with different motivations. Of course, the profit providers want to produce a high level of returns. Therefore, different motivations among different types of providers based on ownership resulted in the different distribution of the supply of providers through social class.

<Figure 6> shows that the tendency of different types of providers entering the market. Based on ownership, during the past five years in Japan the service organizations that

rapidly increased were medical groups (78% increase between 2001 and 2004), for-profit companies (123%), and special NPOs (193%). The price of services within the health service is relatively high compared with other services. Thus the number of services including health care services is relatively greater. Conversely, non-profit organizations that provide simple services with low prices did not significantly increase. In Japan's LTCI, the benefit level, i.e. the prices for service including health care, is much higher compared with the services with simple care services. Health facilities require a high level of capital, thus only the profit organizations can enter the market. The non-profit sector usually consists of small and low-budget organizations. On the other hand, the facilities that had been directly provided by the local governments decreased at the rate of 4% from 2001 to 2004. This means that the local government in Japan did not invest in building public service facilities.

< Figure 6 > Changes in Home Care Providers in Japan



Source: Ministry of Health, Labor, and Welfare in Japan. Surveys of the long-term care services. Annuals.

The inequitable supply of providers due to the price system resulted in discrimination especially against low-income people. This also meant a lack of freedom of choice in services

from the perspective of the purchasers. Setting the various regulations in the benefit provisions, such as the upper limit of the benefits themselves, implies a reduced choice for the purchasers, although they have diverse provider choices under the assessed benefit level and its price. The problem is that the choices are not balanced and equitable for everyone insured. In other words, the supply of institutional care has been restricted. The Japanese government has allowed only non-profit organizations to provide institutional care services, with the exception of the health care service sectors. There has been quite a long waiting line for the elderly disabled to receive institutional care. At the same time, the low prices of the various home care services, including care management, affected the quality of their services.

Therefore, the price-setting and regulation system inherent in the program structure of LTCI has a built-in dilemma for the effective creation of the quasi-market and its efficient operation. Cost control was one of the main reasons that the social insurance system was adopted. The insurance system with the distorted quasi-market service delivery has been more effective in terms of the concept of 'crude efficiency', which means cost containment. But in terms of the productive efficiency, which provides better services,

In Japan, the 10% co-payment system has played an important role in controlling the demands of LTC services. Many research results reveal that the co-payment system systematically discriminates against low-income elders, preventing purchase of the provider's services. Korea also adopted the co-payment system with 20% for the institutional care and 15% for the home care. It is very clear from the experience of Japan that Korea's high-level co-payment system would restrict the choices of the low-income elderly. The budget ceiling system also restricted the providers' service quality.

All these measures of price regulation for saving the costs of the insurance program contributes to the distortion of market operation by being barriers to the consumers' choice as well as the providers' market entries. They also are the main reasons for lowering the quality of the services.

Current Status of LTC Providers and Future Prospects in Korea

It has been just three months since Korea started to implement LTCI. Therefore, any comprehensive and specific data about the performances of Korea's quasi-market for LTCI are not available at this time. Thus, based on the Japanese experiences discussed above and

Korea's current status regarding LTC facilities just before LTCI started, we attempt to infer the future effects of Korea's price setting and related regulations on the provider's entering the market and competition, and consequently the clients' choices and the quality and equity issues of Korea's LTCI. In other words, the current status of service facilities for the old-aged will be either institutional legacies or initial conditions for the new Korean LTCI.

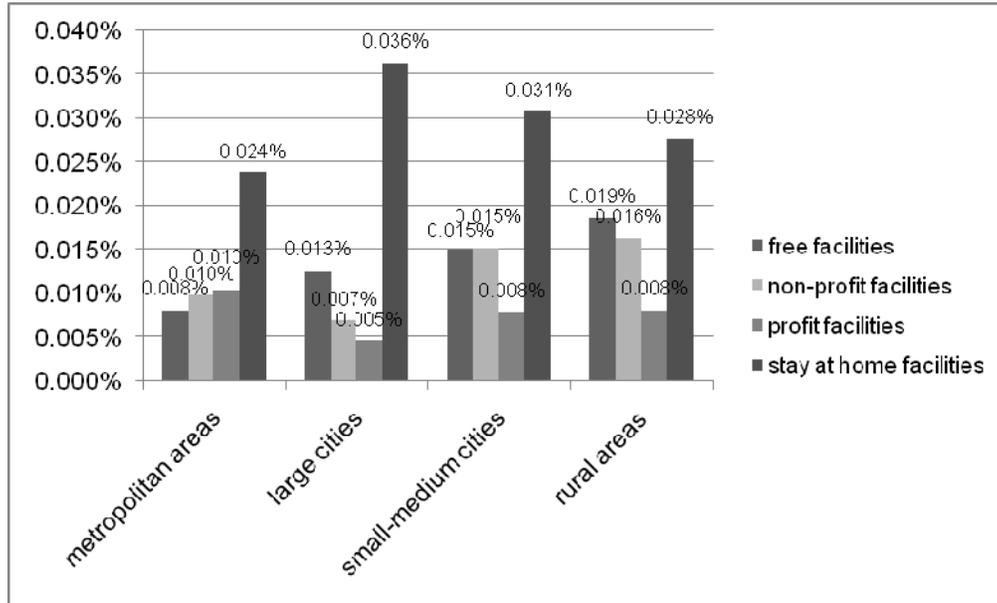
In Korea, there are largely four different categories of service facilities for the old-aged; i) free facilities, most of which are non-profit financed by government subsidies and a few that are run by the local governments; ii) non-profit facilities, most of which are non-profit financed by user's charges and government subsidies, iii) profit facilities, whose motivation is profit in the private market (all of these three facilities serve for the institutional care of LTCI); and iv) home care facilities, which consist of daycare facilities and visiting care service workers; they are either non-profit or profit.

Here I will evaluate the current status of the providers upon two criteria: geographical regions and different service types. This analysis will deliver some insights on the future possibilities of the problems of the quasi-market that Korea will face. Korean society's regional inequalities are very high; half of the Korean population lives in the metropolitan area surrounding Seoul. In the rural area, on the other hand, most of the population is the old-aged, most of who will be the clients for LTCI. Between these two extreme regions, we divided into two regional groups; eight large cities and small and medium cities. Therefore, there is no meaning for the simple total number of facilities by regions. Thus, in order to reflect the demand factor, the numbers are divided by the eligible population for LTCI whose age is greater than 65.

<Figure 7> shows the regional distribution of the four different types of facilities for LTCI in Korea. Interestingly, more free facilities are located in the rural area. Non-profit organizations are fairly well distributed from the rural areas to the small-medium cities, while home care facilities are concentrated in the large city areas. The profit sector, as we expected, is the metropolitan area; nonetheless, the small-medium cities and the rural areas have a fair number of the profit facilities. Perhaps they are mostly small-scale business facilities. The overall picture reveals that service facilities for LTCI based on the potential demand are fairly distributed. So it will be interesting to see how the price setting in Korea will affect the behaviors of the potential providers. Significantly, Japan has heavily regulated the entrance of the profit organizations into the institutional care for fear that it could increase the demand

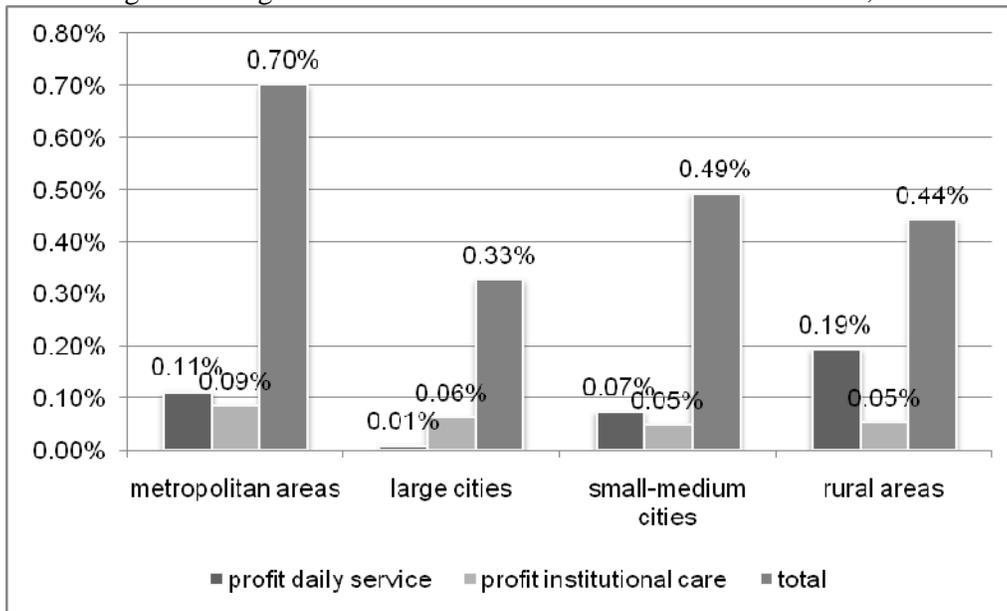
and costs of LTCI. But the Korean government allowed the entry of the profit sector into the institutional care. But as we have seen above, the prices in the Korean LTCI are much lower than those in Japan. It remains to be seen.

<Figure 7> Regional Distribution of Different Types of Care Services in Korea
(% of 65+ older)



Source: A Report on the Facilities of the Old-Aged, Ministry for Health, Welfare and Family Affairs, 2008.

<Figure 8> Regional Distribution of the Profit Facilities in Korea, 2008

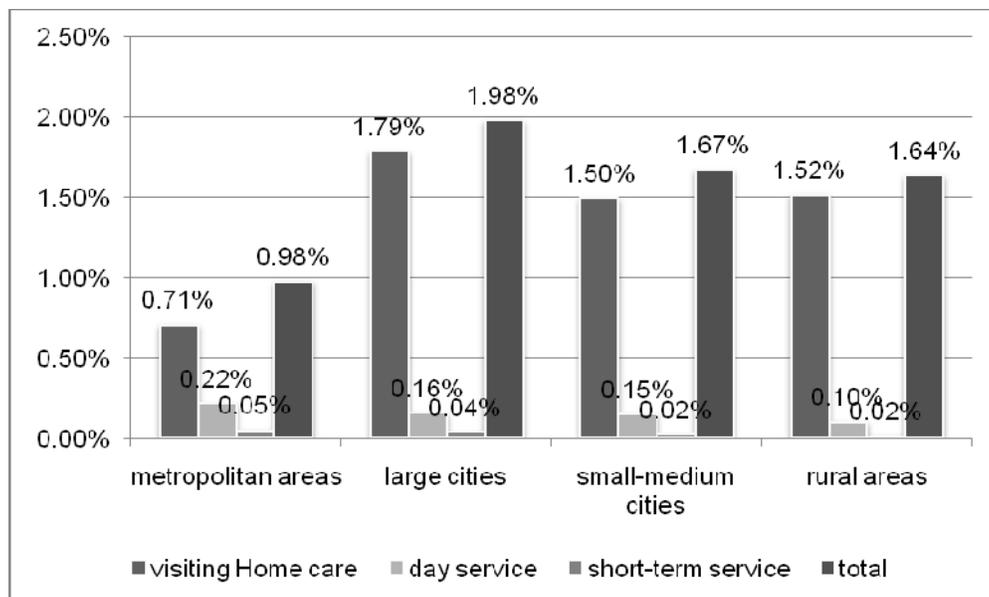


Source: A Report on the Facilities of the Old-Aged, Ministry for Health, Welfare and Family Affairs, 2008.

<Figure 9> indicates the supply of different types of service providers among the home care services. What is clear from this data is that the metropolitan areas do not have sufficient home care services, compared with other regions. According to the statistics, the rural area and small-medium cities have a fairly good supply of providers, but their service qualities are another matter. At this time we cannot get the quality data. It is expected that the surveys on the qualities will be reported soon.

Perhaps, as in Japan, where the demand for home care has been sharply increasing, Korea will have high demand for home care services. However, most services will be provided with poorly equipped service workers and facilities. Short-term services, especially, are in very short supply. This area has some difficulties in rapidly increasing supply because the service requires a certain level of professional workers and equipment.

<Figure 9>Supply of Different Types of Home care service



Source: A Report on the Facilities of the Old-Aged, Ministry for Health, Welfare and Family Affairs, 2008. Korea.

3) Information Asymmetries

Addressing information asymmetries is another significant institutional condition to make an effective function in both a pure market and a quasi-market. In a perfect market, all

information is incorporated in the price; in an imperfect market, price does not play an exclusive role and thus additional information is needed. Therefore, government regulations or the government's direct production is usually required for the goods with a high level of information asymmetries (Ludo and Steurs, 2008). Therefore, in addition to fair price setting, other institutions are properly arranged and working to compensate for information failure. There are three measures to correct the information asymmetries in LTCI: i) eligibility (need) assessment, ii) care management, and iii) monitoring providers.

Eligibility Assessment in Japan and Korea

In LTCI, the benefit entitlements are basically given to the insured regardless of the actual needs. Instead, the eligibility test is conducted under the assumption that the clients do not have the correct information about their own needs in order to determine their eligibility and benefit level. Therefore, the eligibility assessment primarily limits the client's choices and, consequently, the process and the result of the assessment should be fair and transparent. However, in reality the eligibility assessment has been used as a double-edged strategy for controlling demand and at the same time solving the information failure on the part of the clients.

How far is the need assessment properly working for addressing information failure and compensating the client's choices? Korea and Japan have very similar institutional arrangement in this area. The objective committee, which includes a doctor and other professionals in the given geographical area or local government, determines the eligibility and the levels of disability upon the client's application. In Japan, the earlier process where local government officials (often untrained) made the key decision was criticized as subjective, arbitrary, and unfair. Today, the Japanese government tries to make the eligibility assessment process appear objective and fair.

There are two steps; first is the questionnaire to assess the accurate need: ADL (activities of Daily Living criteria, and then an algorithm based on statistical analysis to sort the responses into six categories of disability (Japan), three categories of disability level (Korea). Second, an independent committee appointed by the mayor then reviews the results, together with a brief report from the assessor and a form from the applicant's doctor on their medical condition (Chang, 2007). This committee, which includes a doctor and other

professionals, may adjust the eligibility level up or down (usually up), and does so in about one-sixth of the cases. Adverse decisions may be appealed to a higher-level committee. If this process is not working well, it means that the information asymmetries are not properly solved. Nonetheless, there are still some critics of this process in Japan. The process is still somehow arbitrary or showing favoritism; six levels are too arbitrary. In Korea, the government implemented a pretest project three times. Similar problems were reported.

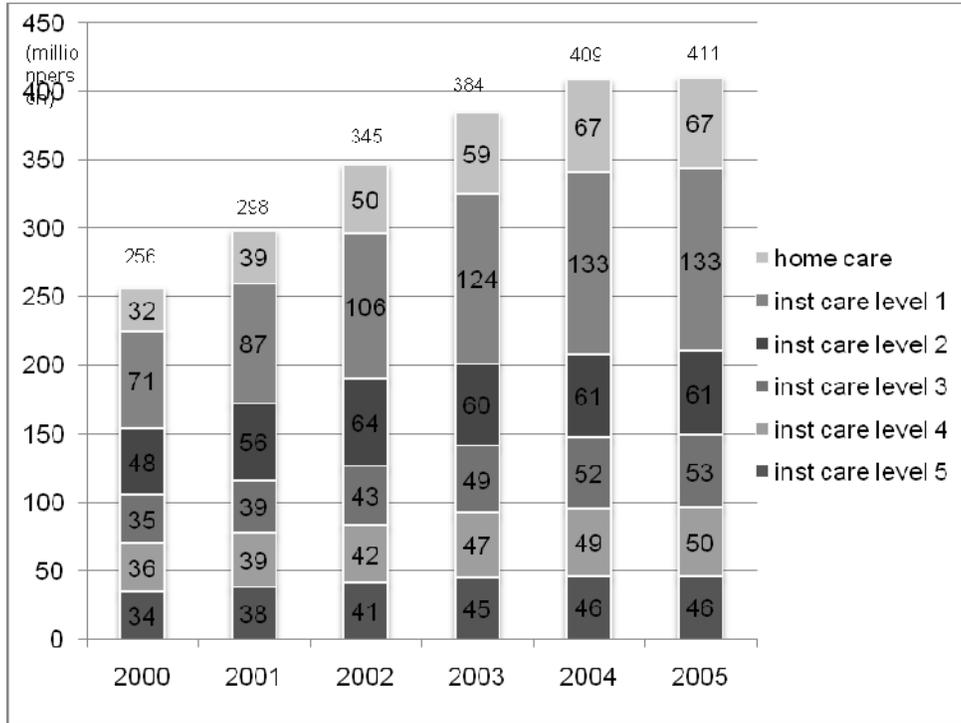
Korea's three levels of eligibility, mainly based on the degree of disabilities of the old-aged, have been criticized as insufficient to differentiate the proper needs of the old-aged. Within physically light disabilities, where the benefit limits are low, there are many different types of disabilities that require special care, such as dementia in the elderly. The Japan case, even with five levels of eligibility, clearly shows that clients suffering from dementia were systematically discriminated against in the predetermined ADL questionnaire. Japan recently changed this rule by loosening the assessment scores for old-aged clients who suffered from dementia. Both countries actually designed the programs by focusing on cost containment and the restrictive eligibility rule, and thus the choices of the clients are inherently limited in the program itself.

In relation to this problem, another interesting case in Japan can be found on the demand side of LTCI since its implementation in 2001, specifically concerning the trend of the eligibility-number determination (although the rejected rate is unavailable). <Figure 10> and <Figure 11> show that demand for institutional care has been relatively constant, while a light level of disabilities (institutional care level 1 and home care) is rapidly increasing. It seems that the Japanese case properly controlled demand for cost containment. However, it is reported that the main reason that the demand for institutional care, especially institutional long-term care (level 5), remained constant was that the supply itself had been very limited and thus there had been a long waiting line for such care.

The government policy does not allow profit organizations to enter this market, with the exception of the health care facilities – only the non-profit and public organizations. There are also political and cultural reasons why Japan's professional social workers and doctors do not want the profit sector to enter the institutional care area. They believe partially that this area is traditionally non-profit and partially because social workers do not want their professional position in this area to be eroded. As we have seen <Figure 6> above, the local governments have not built additional facilities for the public. In other words, the government

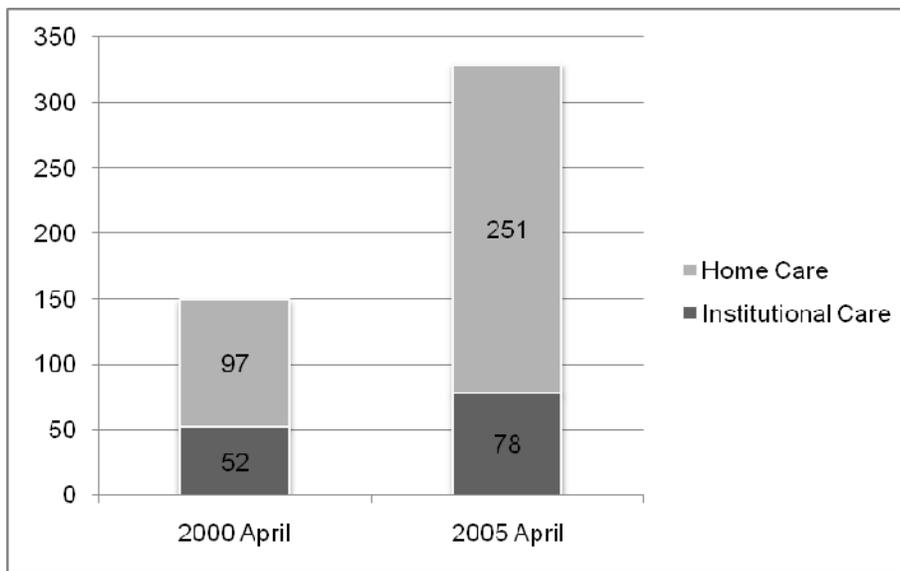
has controlled both the demand and supply side of LTCI. In fact, the client's choices are heavily limited.

<Figure 10> Number of Eligible Clients by Eligibility Assessment in Japan



Source: Annual Report on the Long-term Care Insurance, the Ministry for Health, Labor and Welfare, Japan.

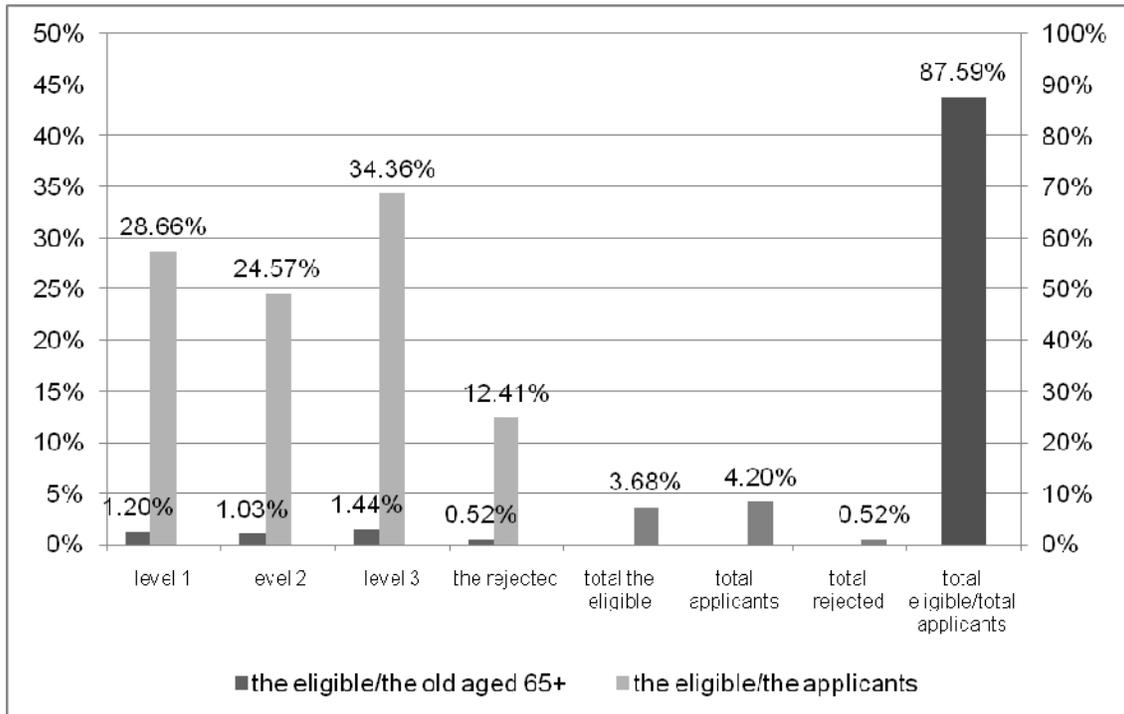
<Figure 11> Trend of Beneficiaries



Source: Annual Report on the Long-term Care Insurance, the Ministry for Health, Labor and Welfare, Japan.

What has happened to Korea during the past three months since the implementation of LTCI? The Korean case will be evaluated with the accepted rate for the application. As already mentioned above, the numbers in the data are used as ones that have been transformed into a percentage of those aged 65 and older. As in Japan, the largest group of beneficiaries was the old-aged with light disabilities, the level 3. The next group was those ones with serious disabilities, requiring institutional care. In Korea, there is quite a high level of institutional care beneficiaries. We can interpret that there have been potential clients in this level before the implementation of the LTCI.

<Figure 12> Acceptance rate according the levels



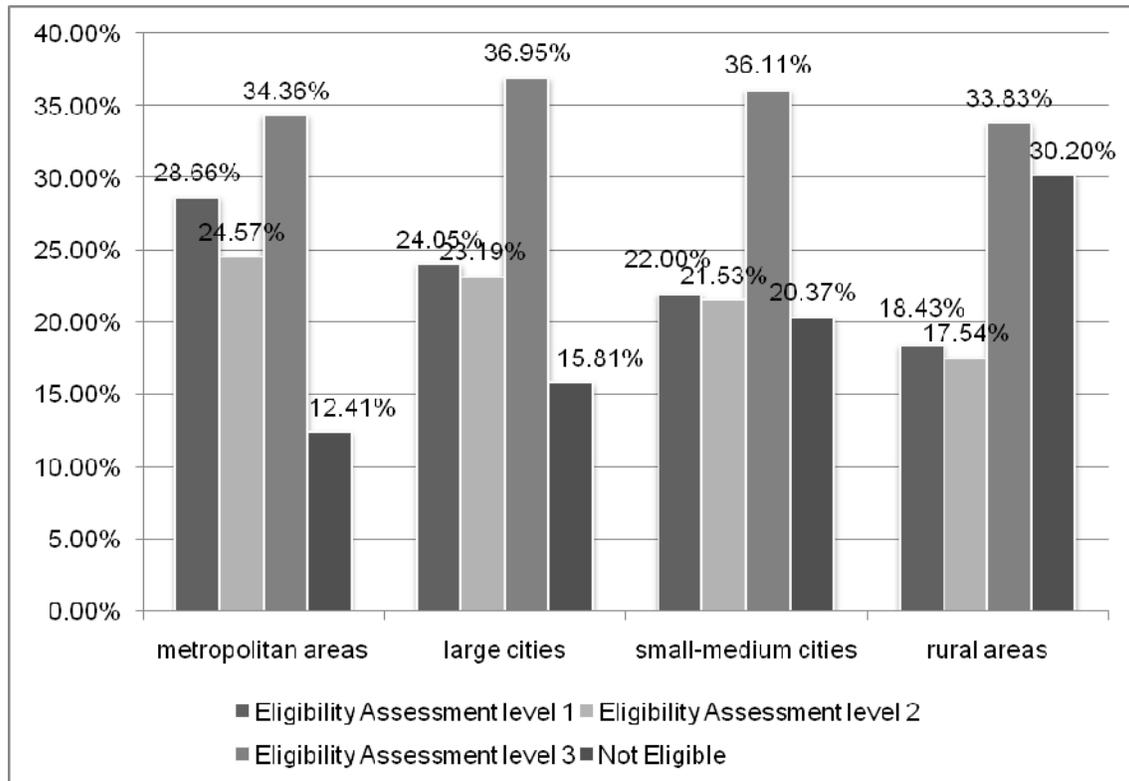
Source: Current Status of the Eligibility Assessment, the LTCI website, <http://www.longtermcare.or.kr/portal/site/nydev/>

The total acceptance rate during the past three months was 87.95%. It seems to be high, which means somehow generous. However, we cannot evaluate whether this rate is high or not at this time. We do not have comparable data for the Japanese care. After a certain period of time, we will be able to see whether this rate is constant over time or the rate could

decrease due to the cost-containment policy.

<Figure 13> shows the acceptance rate by regions and eligibility levels. Overall, it appears that eligibility was fairly distributed by regions. However, if we look closely at the eligibility distribution by levels, we find the regional differences at the acceptance rate. The rejection rate for the applicants was highest in the rural areas. Here, 30.20% of the applicants were rejected, while 12.41% were rejected in the metropolitan areas. There are two different interpretations possible: i) there is a high demand in the rural areas, but the restricted eligibility rule increased the rejection rate; ii) the metropolitan areas have generous assessment compared with the rural areas. We need to observe these differences in terms of equity criterion over time.

<Figure 13> Eligibility Rate by Regions and Levels in Korea



Source: Current Status of the Eligibility Assessment, the LTCI website, <http://www.longtermcare.or.kr/portal/site/nydev/>

Care Management in Japan

Care management is another institutional arrangement that corrects the information asymmetries in the quasi-market from the client's choice side. There are varieties of services and suppliers in the quasi-market in the LTCI. The institutional feature of the quasi-market in the LTC as in other social service areas is biased toward the supplier's side because the professionals tend to determine the choices of the clients. In this sense, care managers in the LTC play an important coordinator in solving information asymmetries for the client's side.

Japan has a care management system, while Korea does not have one at this time. In Japan, the care management system created many problems. First of all, care managers in Japan are not independent from the providers. Care managers in various countries differ greatly in their qualification requirements, status and employment arrangements—an indication of the diversity of approaches to LTIC.

However, Japan lacked the three human profession resources for the LTC; independent care managers; a pool of trained personnel, and an appropriate administrative framework. In order to meet a high demand of care managers, the government allows a loosened care management system. Thus, most of these care managers are employed by service providers and clients can freely change their care manager. This loosened system induces the commercial providers to increase the care services, in other words, the overuse of the services. Many ill behaviors of the case managers were reported.

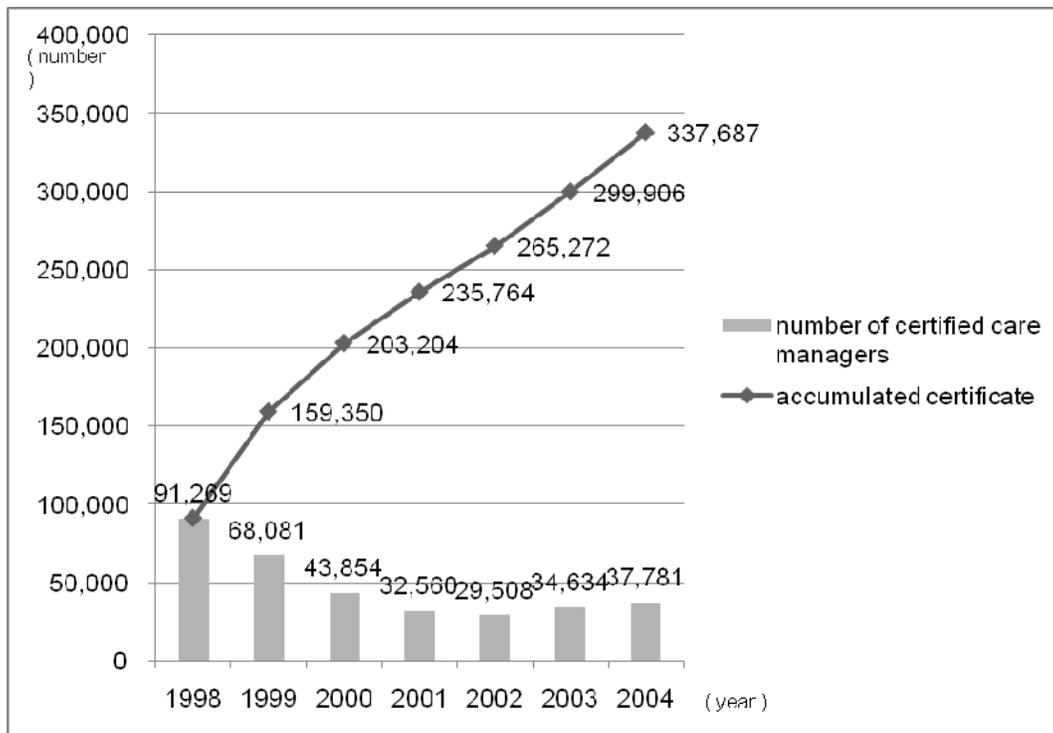
Second, there was no systematic education program of care managers as professionals. The government decided to certify care managers on the basis of relevant experience and a written examination, to give them two weekends worth of training, and in effect encourage the pattern that managers work for provider organizations. Most care managers were either compelled to take the exam by their employers. Of course, a substantial number of case managers decided on their own to enter the field from the idealistic motives of helping older people. The problem is that most care managers are under-paid and overworked, as we have seen above (<Figure 6>), and are forced to spend all their time on financial management rather. They do not have sufficient time for personal counseling and service coordination, which are their original jobs.

Therefore, the Japanese government sees low morale among care managers as a serious problem. It has begun to implement various training and supporting programs and

plans to increase fees. There is also discussion on adopting a system of super-care managers to deal with more specialized care services and the management of care managers. It is likely the system has become too institutionalized for such a radical reform. Care management aside, the most significant innovation in service provision occurred in the community-based care sector: the decisive shift from public or contracted-out services by monopoly providers. Today, for-profit companies and new-style non-profit organizations can easily obtain licenses for LTCI practice and directly compete with traditional public and quasi-public agencies. The goals for this reform were responsiveness, flexibility, quantity control via competition and consumer choice, and efficiency. It was accomplished despite objections from traditional social welfare specialists who were deeply suspicious of the profit motive and what they saw as American-style marketization social policy.

<Figure 14> shows the trend of the number of certified care managers in Japan. Government began to regulate the certified system to supply professional workers. The number of case managers is increasing, but the number of certified case managers over the years is decreasing.

<Figure 14> Trend of the Number of Certified Care Managers in Japan



Source: Annual Report on the Long-term Care Insurance, the Ministry for Health, Labor and Welfare, Japan.

In Korea, the care management system has not yet been institutionalized. There was no monitoring function of the qualities of services. There are strong calls by professionals and academics in Korea for a good case management system for the clients' better choices of their services.

Monitoring Providers in Japan and Korea

The monitoring quality is an essential part of any quasi-market system. Otherwise, providers may engage in what Williamson calls opportunistic behavior, exploiting their informational advantage to reduce costs at the expense of quality (Williamson, 1975). It is known that there are two ways that the providers choose: moral hazard and adverse selection. In the former case, the providers will be apt to cheat with the quality of services or the inducement of overuse of the services; in the latter case, the providers choose the clients with the least risk, given the price, which is cream-skimming.

In fact, it is not easy to create the institutional conditions where the providers enter the market competitively and better choices and services are available for the clients. Indeed, those countries which previously did not have sufficient public infrastructures for social care tend to implement loosened regulations on the providers' entries into the service market. Furthermore, given the low-price setting, the providers' motivation is more profit-oriented and their moral hazards become higher. Therefore, the protection of clients from fraud and victimization, ensuring quality services, and responding to complaints are important issue in the well-functioning of the quasi-market.

In Japan, many significant incidents of poor conduct on the part of the supplier have been reported. Among them, the recent COMSN (Community Medical Systems and Network) event provided a big surprise for Japanese society. The COMSN has been quite well-known and is the largest visiting care business with a wide branch network in Japan. The COMSN, including other LTC organizations, had claimed fraudulent treatment services to the insurance fund, that is, a more excessive amount of service provisions than they actually provided. This illegal and fraudulent claim had been, in fact, common practice among the providers. Since then, the Japanese government reregulated the providers' entry and provisions. However, it is not easy to monitor all the behaviors of the providers because of

high administrative costs.

Therefore, the government's capacity to monitor the providers' behaviors and the quality of services through input, process and output is very important.

4) Transaction Costs

As mentioned above in the theoretical part, the problems of transaction costs in the quasi-market are dependent upon the characteristics of programs. The problems of the transaction costs are more about the transaction processes between providers and purchasers. Therefore, the more competition and choices, the higher transaction costs. In fact, it is not easy to measure the transaction cost.

In addition, the cost associated with market transactions may be particularly acute in the presence of uncertainty. However, the uncertainty in the long-term care service is relatively low compared with health care service because the older people are getting, the probability of the need of the long-term care is getting higher.

As we have seen so far, the LTCIs in both countries are the regulated ones; the clients' choices are not many; the providers' service provisions are quite similar given the fixed price system. Therefore, the transaction costs in the LTCI are more related to the government regulations rather than the market structure. In this sense, the measures and means for the reduction of the transaction costs are parallel with those in the information asymmetries.

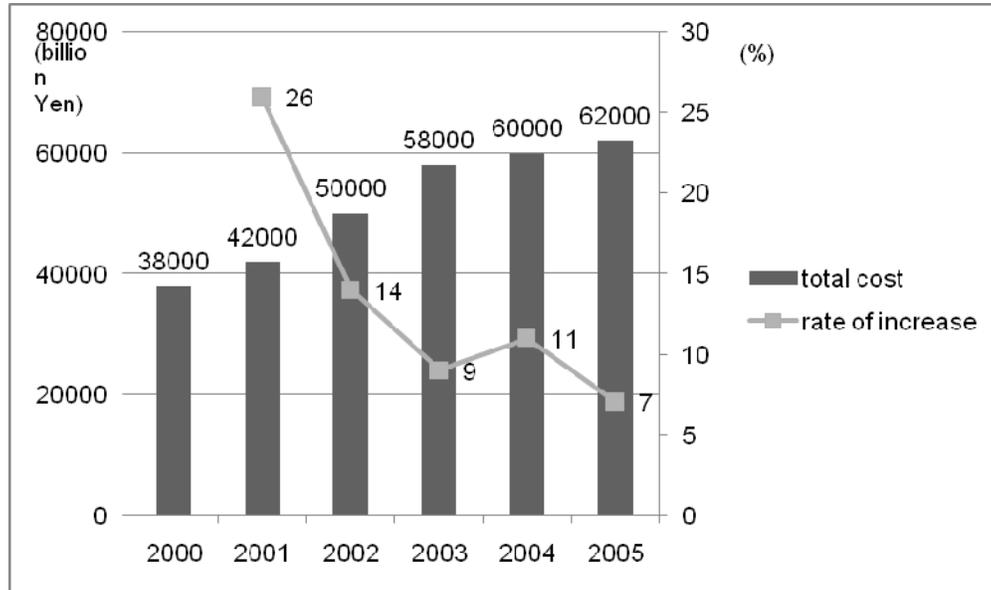
2. Financial Sustainability

The Japanese government has shown an increasing concern for financial sustainability. At this time, it appears that it has managed well in terms of cost containment at the expense of the quality. <Figure15 > reveals that after the rapid growth of insurance expenditure in the early period, the increasing rate in the later period is in decline.

However, if we look at the trend of the increasing pattern of the insurance premium, the financial sustainability issue is not in good shape. As we can see <Figure 16>, the insurance premium is consistently increasing, putting a greater financial burden on the low-income groups. Therefore, the government will face a political issue over the equity concern,

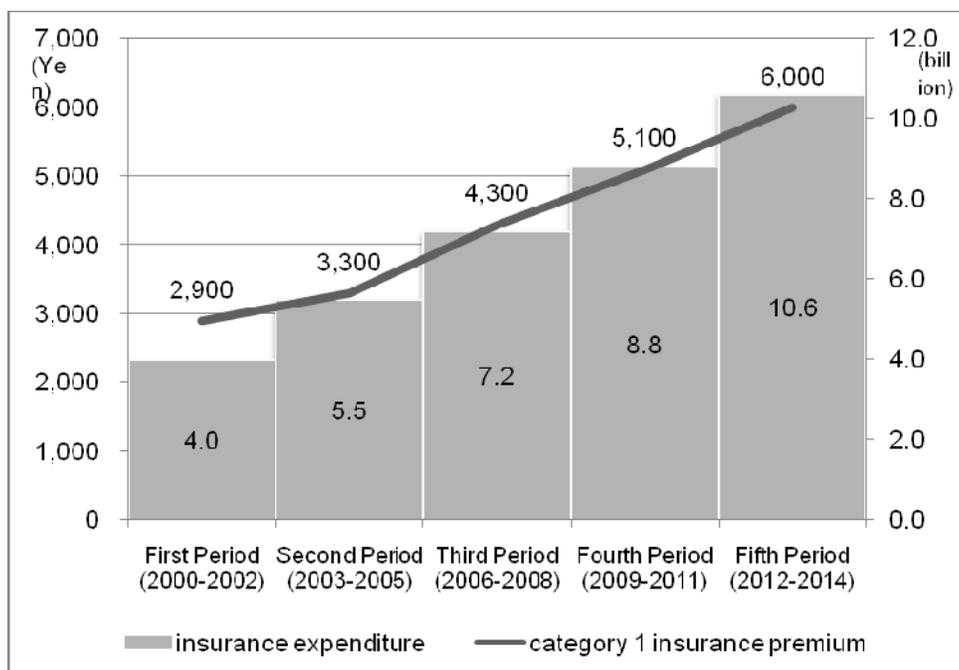
sharing costs. The insurance form has a reverse effect in income distribution. As the premium increases with the demand, the low-income group will feel a greater financial burden. Therefore, it is questionable with the financial sustainability of the insurance form of the long-term care. It might require more involvement of government tax into the insurance system to subsidize the low income people. Then this issue turns into a political matter.

<Figure 15>Trend of Insurance Expenditure



Source: Annual Report on the Long-term Care Insurance, the Ministry of Health, Labor and Welfare, Japan.

<Figure 16> Trend of increase in insurance premium and expenditure in Japan



Source: Annual Report on the Long-term Care Insurance, the Ministry of Health, Labor, and Welfare, Japan.

IV. Conclusion: What are the lessons from the Experiences of Japan and Korea?

So far, we have examined the problems and issues of LTCI in Japan and Korea in terms of the quasi-market theory and focused on the question of whether both countries' delivery system is working well according to its promises. Both countries chose the quasi-market system in the sense that the LTCI will have merits regarding cost-containment, universal entitlement, and the creation of the quasi-market, given the lack of infrastructure and very fast rise of long-term care demand.

As we have seen in the Japanese and Korean cases of LTCI, the quasi-market is not working as the theory commands. It seems that the quasi-market does not exist as it is. The quasi-market had inherent problems to meet its promises; quality, efficiency, responsiveness, equity. Much research has been done on the quasi-market, including various other areas such as education, housing, and employment services. More government regulation and supporting functions are required as the quasi-market system is gradually incorporated in the program's delivery system. This means that the quasi-market can work well only with the good government capacity to regulate the problems of the quasi-market. Therefore, the institutional design for each social care system is more important than the simple existence of the quasi-market. And it is very difficult to create such institutional conditions for the well-functioning

of the quasi-market.

However, it does not mean that the quasi-market is useless. On the contrary, in the future when the demand for various social services is continuously increasing due to the demographic and industrial structural changes, the incorporation and adoption of a certain form of the quasi-market delivery system to the various public service programs will be crucial. Thus, the important thing that we should note is how well we design the institutions and programs given the conditions rather than the simple belief of the quasi-market as a myth.

In this context, the effectiveness and viability of the quasi-market system is crucially affected by the previous institutional legacies and the characteristics of the welfare regime in which the LTCI is operating. Institutional features of the overall welfare system are important in determining the degree of the qualities and main parameters of the quasi-markets such as the motivation, less bureaucratization, and the trust between the major agencies.

Japan and Korea started the LTCI without the sufficient construction of its infrastructure, although the Japanese case was better than Korea's. Therefore, the motivations of the major agencies are more profit-oriented rather than toward social rights. The Japanese case reveals more concerns with equity, compared with Korea. As a new starter, the Korean program has much to be desired. Therefore, the Japanese experiences will keep providing very useful lessons to the Korean case as a late developer. And then both cases will provide continuous innovative ideas to the newcomers in the future.

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