A Comparative Analysis of Elderly Care Quasi-markets in Japan and Korea

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Ⅰ. Introduction

Recently, reforms responding to the aging society in particular, a number of reforms surrounding supply system of long-term care for the elderly are being carried out around the world. For instance, a reform attempts to introduce a market principle into service supply system to provide efficient and high-quality service through competition among suppliers.

In Japan, as part of "Social Welfare Basic Structure Reform", Long-term Care Insurance Act was legislated in 1997 (enforced in April, 2000) and it became an moment for expanding market principle into welfare. The expansion of market principle into Long-term Care service made it possible for various service suppliers to enter the market and for users to choose services. In addition, the role of the government was reduced from the predominant supplier to the body of paying expense.

In the meantime, the final responsibility to provide the social welfare service should be generally borne by the government. Accordingly, while service is supplied in market principle, but perfect competition could not be expected because of strong intervention by the government. As this shows, the system where there exist competition in service supply and the government places various limitation with laws for guaranteeing rights of users is called "Quasi-Market".

Great Britain first introduced Quasi-Market mechanism into welfare service supply system. The representative study of the Great Britain on Quasi-Market is the one by J. Le Grand and W. Bartlett. They started the study on Quasi-Market in 1989 and "Quasi-Market theory" advocated by them has significantly affected the study on Quasi-Market not only in the Great Britain but also in Japan.

Meanwhile, Korea also introduced Long-term Care Insurance for the elderly in 2008 and Quasi-Market mechanism begins to function in welfare service supply system. It is well known that it was formulated based on Japan's Long-term Care Insurance Schemes, and it has very similar structure to

Japan's Quasi-Market of care service. However, in the case of Korea, the study on Quasi-Market has not been done vigorously in welfare field yet. Therefore, regarding definition and factors of Quasi-Market, Japan's Long-term Care Insurance Schemes was referred.
The purpose of this study is to compare Japan's Long-term Care Insurance Schemes with Korea's counterpart in the framework of Quasi-Market. Chapter Ⅱ introduces definition of Quasi-Market by J. Le Grand, and explains factors of Quasi-Market of Long-term Care Insurance Schemes of Japan and Korea. Chapter Ⅲ compares structures of Quasi-Market of Japan and Korea centering on two factors of "Quasi" and "Market".

Ⅱ. What is Quasi-Market?

What is defined as Quasi-Market among welfare service provision mechanism? In the Great Britain what is definition of Quasi-Market and how the definition is evaluated in Japan?

1. Definition of "Quasi-Market" by J. Le Grand

Definition of "Quasi-Market" was first formulated by J. Le Grand. According to his definition, "Market" suggests that the system was changed from the one where the government exclusively provides service to the competitive and independent supply system and "Quasi" suggests that there exist non-profit organizations which competed against profit organizations for users and purchasing power is in the form of needs or vouchers rather than money. Service is bought by purchasing agent and then distributed to users (Le Grand 1993:10).

Koyama (2004), a Japanese researcher pointed out several problems about the definition by J. Le Grand. First, regarding the reason that Quasi-Market is a "market", he argued as the following.
(1) As there is an expression of "monopolistic market", market is not always competitive. (2) If the word of "independent" is used as the opposite concept of "the government", national (public) suppliers could be excluded from the concept of suppliers in Quasi-Market. (3) That users are able to

make a choice is excluded from the reasons, which Le Grand mentions, why Quasi-Market is a market.

Next, among the reasons why Quasi-Market is "quasi", regarding the point that "there exist non-profit organizations which compete against profit organizations", Koyama argued that in economics, whether suppliers pursue profits or not is dealt with as an issue of motivation of economic units (Koyama 2004:134).
Koyama is the only researcher who criticizes the definition by J. Le Grand, and I make my comments to his opinion. First, regarding whether it is profit-making or non-profit or not, in the study of social welfare, the meaning of pursuing profits with the introduction of Quasi-Market is significant. Usually, supply side is a non-profit organization and users don't pay for the service in cash, which has been regarded as a common sense. Considering that, including mixed existence of "profit organizations and non-profit organizations" is very important. In particular, it is inevitable for the definition that distinguishes Quasi-Market from the standpoint of social welfare study.

Next we examine Koyama's previous notice that "service expense is borne by the government, not by users" is omitted in the definition by J. Le Grand. For instance of Long-term Care Insurance Schemes, considering that ten percent of costs is borne by the persons concerned for service, strictly speaking, it is more proper to express "joint burden sharing of users and the government".

The definition by J. Le Grand, criticism by Koyama about the definition, and the author' opinions were explained respectively. Next, Le Grand made definitions of Quasi-Market from the perspective of public service reform in fields such as education, medical care, and community care of the Great Britain. Therefore, it is hard to say that it can fully reflect the situation of Japan, as it is suitable for the situation of the Great Britain. For example, among the definition by J. Le Grand, the expression that "service is bought by purchase agent and then distributed to users" applies to NHS of the Great Britain but no to Long-term Care Insurance Schemes of Japan. In Japan, users have the right to buy service, and users, who are assessed as the one worthy of care, choose which service should be bought and conclude a

contract directly with service supplier.

As the above description shows, even though there are limits to apply the definition of Quasi-Market of the Great Britain to Japan's Quasi-Market situation, regarding that it offers a kind of basis or reference for related studies, the theory of J. Le Grand is very useful.

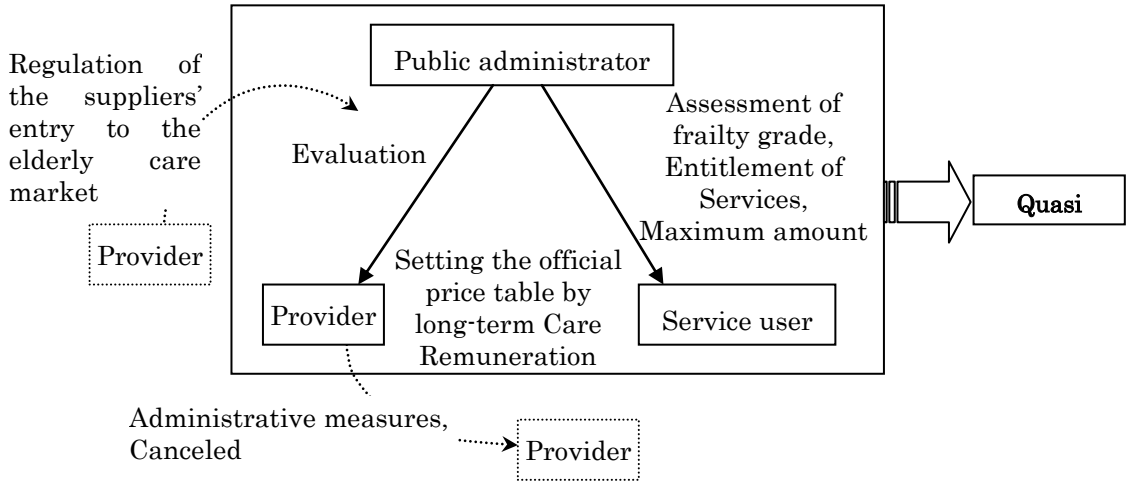
2. Factors of "Quasi-Market" in long-term care service

The discussion that which parts should be regarded as "scope of Quasi-Market" under the situation, where market principle and public regulation co-exist in welfare supply system for the elderly, has differences of opinion which would depend on academic discipline. When the scope of Quasi-Market is defined in social welfare study, public sector, which is supposed to takes the final responsibility, is placed in the center, the area that is free from public regulations, or "free competition, and users' responsibility" part are focused . This is because of the difference between economic activity and social welfare services, and because of differences in basic idea regarding which comes first among public or individuals' interest. Then, first, what is the "Quasi" part when it comes to care service Quasi-Market from the perspective of social welfare study, and second, the meaning of "Market" part would be examined in this section.

1) Factor of "Quasi" in Quasi-Market

First, regarding "Quasi" part of Japan's Long-term Care Insurance system, it consists of the part where the administration participate or "public regulation" exists (Figure 1).

Figure 1. Factor of "Quasi" in Quasi-Market in Japan's Long-term Care Schemes



If examined from the supply side

a. Market entrance of various private organizations is encouraged and service that can be provided is confined depending on kinds of service or characteristics of organizations[1]. In the case of Long-term Care Insurance, the service that can be provided by profit organizations is confined to institutional care service.
b. In addition, even in organization that can provide service, there are certain standard for facility and personnel.
c. Even after being permitted as an organization offering service, information should be released to public institutions and there is obligation to respond to evaluation.
d. In the case of illegal behavior, there are cases where administrative measures are taken or designation cancel is taken.
e. Depending on characteristics of facility and institution, there are cases were expenses for operation is subsidized by the administration.

Second, from the demand side

a. For use of care service, users need to be assessed as those who need care from the administration.
b. When using service after being graded, because there are maximum limit of service usage expressed by money-term in each grade, insurance can be applied to the part used usually within this limit.
c. Service institution can be chosen, and by the contract between institution and users, service are provided. As the service price is fixed in the form of care remuneration, service is used based on price and the needs.

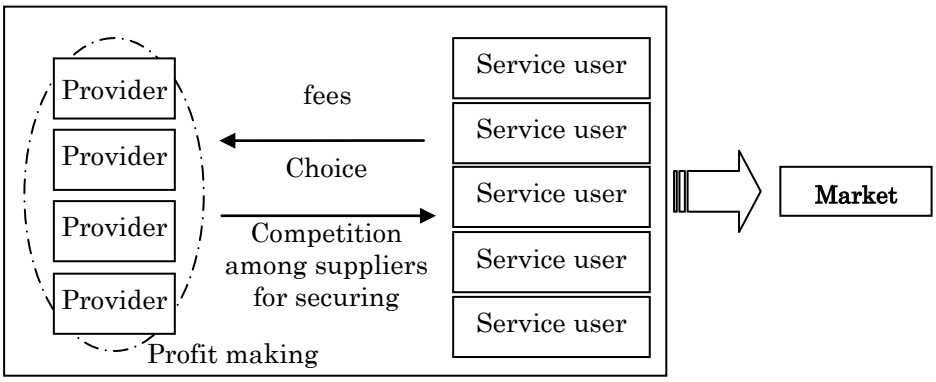
The government allows supply of welfare service, in particular, operation of care insurance service, to be conducted by market principle, but sets the aforementioned restriction to maintain the characteristic of public features in the supply side of service.

[1] For instance, in the case of institutional care service, service can be provided by profit seeking bodies and non-profit seeking bodies. But in the case of residential care service, provision by profit seeking bodies is prohibited, and establishment only by the government, local autonomous organizations and social welfare corporation is approved.

2) Factor of "Market" in Quasi-Market

Factors of "Market" in Quasi-Market are as follows(Figure 2).

Figure 2. Factor of "Market" in Quasi-Market in Japan's Long-term Care Schemes



a. First, there is a point regarding "profit making". Before Long-term Care Insurance Schemes was established, when it comes to social welfare, profit-making was impossible in principle[2], but profit-making became universal with Quasi-Market of care service.
b. Second, there was "competition among suppliers for securing users". As care service provision became a business area, securing users became a task directly related to profit pursuing.
c. Third, "users are able to choose service provider" cane be pointed out. Users are able to choose service supplier, and make service plans based on payment limit amount by degree of care. However, while freedom of users is guaranteed, and the responsibility should be taken by users. It is the basic way of thinking based on market-problem.
d. Lastly, there is a point regarding "payment of used fee". Users have an obligation to pay for the fee for the provided service. Regarding most services, 10%of share to pay is specified, and for other services, there are cases where individuals have to take the full responsibility regarding the amount.

[2] Before care insurance system was introduced, as the bodies which establish social welfare facility, mainly prefectures, municipalities and social welfare corporation were specified. At that time, the services where profit organizations are allowed to participate includes paid-caring and silver service.

As this shows, when it comes to Long-term Care Insurance Schemes, as there exist factors of “public regulations”, with existence of “Quasi” and “Market” principle, and it can be called “Market”.

Ⅲ. Comparative study of quasi-market of elderly care services in Japan and Korea

Here the structure of quasi-market of the long-term care in Japan and Korea is explored with paying attention to two factors of “quasi” and “market”. The relationship between public administrator and providers in the 1st section, those between public administrator and service users in the 2nd section, those between suppliers and service users are examined respectively.

1. The relationship between public administrator and providers

The relationship is explored from the three perspective, namely, 1) regulation of the suppliers’ entry to the elderly care market, 2) regulation / restraint of price competition by setting the official price table, 3)supervision and evaluation by the public administrator.

1) Regulation of the suppliers’ entry to the elderly care market

With the introduction of Long-term Care Insurance Schemes in Japan and Korea, varieties of service delivers, such as social welfare corporations, NPOs, medical corporations, profit-seeking bodies, cooperatives, could enter into the service market to compete each other.

However, all areas of services are not open to varieties of bodies. For example, in Japan, profit-seeking bodies are not allowed to participate in the area of “institutional” care services, resulting that almost all services are exclusively delivered by the social welfare corporations. On the other hand, in the area of residential care, profit-seeking bodies are allowed and in fact over half of the services are delivered by such bodies. We could say that quasi-market of long term care in Japan is featured by the dual structure of “monopoly by the

non-profit bodies in the area of institutional welfare delivery" and "major occupation by the profit-seeking bodies in the area of residential care services".

In contrast with schemes in Japan, all area of services are open to any of bodies including profit-seeking bodies in Korea. In particular, though only corporate bodies are permitted to embark to the long-term care services in Japan, "individuals without juridical (legal) person" could be approved as deliverers. In fact, 60.4 per cent of the welfare institutions in Korea and 88.1 per cent of firms providing residential care services are run are by individuals without juridical person (Seok Jae-Eun 2010). This is a big difference between Japan and Korea.

The above implies that, by the dual structure of "monopoly by the non-profit bodies in the area of institutional welfare delivery" and "major occupation by the profit-seeking bodies in the area of residential care services", Japan has maintained the public nature of care services (=quasi aspect of quasi market) and sought to improve the quality of care by introducing the principle of competition (=market aspect of quasi market). On the other hand, Korea has allowed all types of providers including individuals without juridical person to embark on the service delivery, which is guessed to supplement the quantitative insufficiency of services.

2) Regulation/restraint of price competition by setting the official price table

The prices/fees of care services are officially set (named care remuneration) by the Long-term Care Insurance Act, both in Japan and Korea. It means that "price competition" among service providers is prohibited by the regulation, leading to service quality competition in order to acquire the service users. These schemes prohibiting the price competition in Japan and Korea are very different from the quasi-market of NHS in Great Britain, which allowed the price competition among providers.

"Care remuneration" in Japan (one unit is 10 Yen), which is the exclusive source of providers' earning, is supposed to be revised every three years. Until now there occurred these revisions three times : In the years of 2003

and 2006, diminution revisions had occurred and in 2009 increment revision by three per cent. The main reason of increment revision in 2009 is shortage of care workers which is caused by the sense of "low pay for the hard work". The growing number of turnover and the difficulty to recruit new staffs pushed government to upward revision.
There also exists the same kind of official price setting named Long-term Care Remuneration in Korea. In the case of Korea, the insurer is not municipality but the National Health Insurance Corporation and administered nationwide, that leads no price differences of care services among localities.

Table 1 shows differences of remuneration unit between Japan and Korea for two kinds of elderly care (visiting care services and visiting nursing services).

Table 1. differences of remuneration unit between Japan and Korea for two kinds of elderly care (visiting care services and visiting nursing services)

(unit: yen)

	The time of required	Japan		Korea
		in case of body's care	In case of household	
visiting care service	less than 30minutes	2,540	-	-
	30minutes~59minutes	4,020	2,290	748
	60minutes~89minutes	5,840	2,910	1,128
	90minutes~119minutes	6,670	-	1,495
	120minutes~149minutes	7,500	-	1,869
	150minutes~179minutes	8,330	-	2,114
	180minutes~209minutes	9,160	-	2,345
	210minutes~239minutes	9,990	-	2,562
	more than 240minutes	10,820	-	2,765
visiting nursing service	less than 20minutes	2,850		-
	20minutes~29minutes	4,250		1,915
	30minutes~59minutes	8,300		2,472
	60minutes~90minutes	11,980		3,028

The level of remuneration in Korea stays about 20-25 per cent of those in

Japan. Lim (2010) explains the background of it, saying "it is inevitable in order to mitigate the government's financial burden and to restrain the premiums which insured people must pay".

Due to the low level of remuneration, providers may be tempted to pick up the certain category of clients for whom they can expect to acquire relatively high earnings with the same effort, which is a "cream skimming", or to do fraud/misconduct to request illegally extended bill for services. At the same time it might end up with low pay for the care workers and consequently low quality of services. These are problems and challenges not only for Japan but also Korea.

3) Supervision and assessment by the public administrator

Supervision and assessment by the public administrator is provided by the law both in Japan and Korea. But it is not long since the implementation in Korea, so full-supervision and evaluation are supposed to start in the year of 2011, since then all firms/ institutions will be due to have compulsory assessments once in two years. On top of that, it is planned to give some financial incentives to service-providing firms according to the result of their assessment.

In Japan, there exist "Public research and release system" and "Assessment by the (external) third party" on the service information. The former is prescribed in the 115th article of the Act and the result of those is released yearly on the internet. On the other hand, the latter is not obligatory but just executed to the firms which applied for assessment. The aim of two systems above mentioned is to let clients to make decisions about choosing services easier by informing the contents and quality of care services are which is expected to dissolve "the asymmetry of information" and to correct "the market failure".

2. The relationship between public administrator and service users

1) Entitlement of Services based on the Assessment of frail-grade

Clients must be approved of the entitlement in order to get care services under the Long-term Care Insurance Schemes in Japan and Korea, which is issued based on the assessment of frail-grade. Though some differences can be found, the basic procedure, from application to approval, is similar in both countries as shown below.

Application (to the municipality in Japan, to the National Health Insurance Corporation in Korea) → First step assessment by the computer → Second step assessment based on the medical doctor' opinion → Seven frail- grades in Japan, three grades in Korea

But the difference of approval ratio between two countries must be noticed, 16.5% of the elderly is assessed as being frail in Japan (in the year of 2010) and 5% in Korea (2009).

2) Maximum amount (ceiling) of care service and co-payment

In both countries the maximum amount (ceiling or upper limit) of care services which clients can use is set for each of frail-grade as shown in Table 2 .

Table 2. comparison Japan and Korea on ceiling of care service and co-payment by frail-grade

(unit: yen)

	ceiling of care service (a monthly amount)		co-payment (a monthly amount)	
frail-grade	Japan	Korea	Japan(10%)	Korea(15%)
Support required 1	49,700		4,970	
Support required 2	104,000		10,400	
Care level 1	165,800		16,580	
Care level 2	194,800		19,480	
Care level 3	267,500	57,029	26,750	8,554

Care level 4	306,000	67,984	30,600	10,198
Care level 5	358,300	79,842	35,830	11,976

This table demonstrates that the maximum amount in Korea is about 20 % of those in Japan. However when we take into consideration lower level of care remuneration unit in Korea, which is shown in Table 1, so much difference of the service quantity in the real term does not exist.

Users, who are approved as frail, can use services within these limits, but it is not free. They must pay certain amount when using the services in Japan 10 % for all kinds of services and in Korea 15% for residential services and 20 % for institutional services. If they use services beyond upper limits, they must pay 100 % fees for services by themselves. This co-payment system, in particular 100 % co-payment, was introduced to avoid the abuse or overuse of services, which is a kind of moral hazard, and consequently not to damage the government budget or to lessen the insured's premiums.

3. The relationship between providers and service users: right of choice of service and the care manager

Koyama (2004) defines quasi-market of elderly care services in the Great Britain as "purchase-by-government type" or "purchase-by-care managers type", whereas those of Japan as "choice-by-users type" which means that users are delegated the right of making decision to purchase services.

In Great Britain, a care manager, as a professional agent of service users, is delegated to make decisions about service usage on behalf of clients. How about care manager in Japan? Care manager in Japan plays an important role, as they help clients to make a care plan, which is a package of various care services. But purchasing of service itself is not carried out by care manager. This contrasts with a role of care manager in Great Britain. In Japan care more than one managers are supposed to be in the elderly services' firm. Their jobs are as follows.

a. Grasping of the client's physical/mental and financial condition
b. Making care plan
c. Supporting clients to take procedures of service usage

d. Check and control of service usage according to the care plan

How about care manager in Korea? When applying Koyama's typology which is above mentioned, quasi-market of elderly care in Korea is classified as "choice-by-users type". However, in Korea, the post of care manager is not provided in the Schemes. Instead the role of care manager is held by the staff of the National Health Insurance Corporation and furthermore the detailed job description on the work of care management does not exist. Before the implementation of the Long term care schemes, the introduction of the care manager system had been examined. But in the end, this new type of the certified profession was not introduced. The main reasons of it are as follows:

1) To lessen the complexity of procedure and to increase the accessibility to the service
2) To restrain the administrative costs

On top of that, the fact that residential care services in Korea is not so varied as in Japan promoted this substitute of care manager by the staff.

Ⅳ. Concluding remarks

We examined the structure of elderly care quasi-market in Japan and Korea with noticing aspects of both "quasi" and "market".

To sum up the factor of "Quasi", it consists of "regulation by administration". For instance, there are restriction of service supply depending on characteristic of supply organization, price setting, and evaluation and supervision. This is the mechanism to maintain public aspect, which is peculiar in welfare service, and to control supply and demand.

Market factor consists of "aspects of market principle" such as encouraging participation by various private organizations and guaranteeing the right of choice to users. The reason that market factor is introduced in supply system of welfare service is that there is an intention to save administration cost by utilizing private resources.

Quasi-Market structures in Japan and Korea were compared in this paper.

This Quasi-Market factor does not always remain the same level. In other words, depending on policy situations of each country, factor of "quasi" becomes strong or factor of "market" becomes strong. For example, in Korea, without sufficient establishment of infrastructure, long-term care insurance system for the elderly was implemented. Consequently, for establishing supply-side infrastructure, active participation by private sectors was encouraged by emphasizing the "market" principle. However, two years later since the implementation of the system, problems of excessive supply occurred. Accordingly, for reducing supply, standard for establishment was revised to be stricter and evaluation system was also strengthened leading to emphasis of the "quasi" factor.
Therefore, in terms of operation of care service, there is a need for recognizing that the degree of relax regulation and the degree of the government's intervention are flexible.

Concrete differences of features between Japan and Korea, each of which focuses the relationship 1) between public administrator and suppliers, 2) between public administrator and service users, 3) between providers and service, are summarized in Table 3.

Table 3. Structures of Quasi-Market of Japan and Korea

<table>
<tr><th colspan="2"></th><th>Japan</th><th>Korea</th></tr>
<tr><td rowspan="3">1-(1)</td><td rowspan="3">Regulation of the suppliers' entry to the elderly care market</td><td colspan="2">Residential care service: open to varieties of bodies</td></tr>
<tr><td>Institutional care service: monopoly by the non-profit bodies</td><td>Institutional care service: open to varieties of bodies</td></tr>
<tr><td>only corporate bodies</td><td>possible individuals without juridical(legal) person</td></tr>
<tr><td rowspan="3">1-(2)</td><td rowspan="3">Regulation of price competition by setting the official price table</td><td colspan="2">setting the official price table
- be prohibited "price competition"
- leading to "service quality competition"</td></tr>
<tr><td>regional differences: existent (0.3~0.5% premiums)</td><td>regional differences: non-existent</td></tr>
<tr><td colspan="2">official price's disparity of visiting care service and visiting nursing service: existence</td></tr>
</table>

1-(3)	Supervision and assessment by the public administrator	- Public research and release system - Assessment by the third party	start in the year of 2011
2-(1)	Entitlement of Services based on the Assessment of frail-grade	Application (to the municipality in Japan, to the National Health Insurance Corporation in Korea) → First step assessment by the computer → Second step assessment based on the medical doctor' opinion → Seven frail- grades in Japan, three grades in Korea	
2-(2)	co-payment	10% of costs for all kinds of service	institutional care service: 15%, residential care service: 20%
3	right of choice of service	choice-by-users type	
	care manager	care manager: existent	care manager: non-existent