Policy Analysis of the Community Care Environment in Elderly Care:
Through Comparative Analysis of Japan and South Korea

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Introduction

In the Asian context, it is crucial to recognize that Japan currently holds a leading position in terms of its aging demographic ratio, reaching 29.1% in the year 2022. In comparison, South Korea and Singapore, while trailing behind Japan, are gradually moving towards a similar demographic landscape, with aging ratios of 17.5% and 16.6%, respectively, within the same time frame. Moreover, it is important to note that all three nations face significantly low total fertility rates, with Japan, South Korea, and Singapore reporting rates of 1.27, 0.78, and 1.2, respectively, as of 2022. This situation reflects a notable degree of uniformity in several other Asian nations.

In tandem with demographic transformations, each nation contends with challenges, including the exacerbation of fiscal constraints within the domains of eldercare and healthcare, the amplification of socio-economic disparities, and associated quandaries. The escalating onus not only exerts a direct influence on governmental policies and frameworks but also converges into a nexus of economic sustainability predicaments for families, notably those enmeshed in the economic viability issues pertaining to elderly dementia patients and their familial cohorts.

In response to these demographic challenges, Japan introduced the long-term care insurance (LTCI) system, known as 'Kaigo Hoken', in the year 2000, while South Korea implemented the 'Elderly Long-Term Care Insurance system' in 2008. Subsequent to the introduction of these systems, there have been policy revisions. Although both countries' long-term care schemes are rooted in a social insurance paradigm, their architectural designs actively encourage market engagement within the service provisioning domain. Nevertheless, the noticeable increase in social insurance premiums due to the growing elderly demographic presents a discernible burden for both the beneficiaries of the services and their familial support structures (Choi, 2015).
The transition from conventional institutionalized long-term care paradigms for the elderly to community-based care represents a pervasive and transcendent global trend. This shift is evident not only in Japan but also across di-

verse regions worldwide (Chee, 2016). Furthermore, the reform efforts in community-based and long-term care have evolved into a prominent and conspicuous thematic concern, emphasizing its relevance not limited solely to the United Kingdom but resonating on a global scale(Davies, 1994).

Within the discourse concerning the intricate issue of fiscal sustainability, a recurrent and central theme is the pivotal role of communities. This overarching concept encompasses the anticipation that communities will independently undertake responsibilities in domains of care that extend beyond the ambit of governmental provisions. Consequently, it is paramount that a fundamental shift in policy paradigms be embraced across diverse national contexts. Amidst an array of plausible approaches, the author ardently champions the adoption of aging in the community as the most pragmatic and feasible course of action.

As an illustrative instance, the conceptual formalization of community-based care initially materialized within the United Kingdom. Notably, in the year 1990, the enactment of the National Health Service and Community Care Act signified a momentous juncture in the evolution of community care practices. Within the United Kingdom, the provision of services has been systematically organized in alignment with a community-centric paradigm, maintaining a discernible demarcation between healthcare and social services. This emphasis on community-centric care has persisted over time, enduring as a salient characteristic within the healthcare landscape of the United Kingdom.

In the Japanese context, the year 2005 witnessed a pivotal amendment to the LTCI system. This amendment introduced a heightened emphasis on preventive care, aiming to empower the elderly population to lead self-sufficient lives within their local communities. This shift was achieved through the establishment of a comprehensive community care system and the implementation of community support initiatives. However, a significant policy transformation occurred in 2015, a decade after the initial reform. This policy change involved the reassignment of specific beneficiaries of preventive benefits to community support programs, concurrently with an intent to curtail insurance payouts. Importantly, this transition sought to augment dependence on informal community resources. In essence, the policy direction pivoted towards ensuring the sustainability of the system while balancing financial considerations with the preservation of community-based care initiatives.

In contrast, South Korea has undergone the evolution of an informal sector within the contours of its historical milieu. The establishment of Elderly Comprehensive Welfare Centers stands as a noteworthy illustration of institutions crafted to provide services to the elderly populace, concurrently assuming a preventive role. The proliferation of these centers has transpired on a national scale, expanding to encompass 336 locations as of the year 2022. This expansion notably highlights the central role attributed to communities in the provisioning of welfare services. Subsequently, the introduction of the elderly long-

term care insurance system ensued. Within this policy framework, a discernible accentuation on community-based service provision has emerged, particularly through home-based services. Service delivery within this paradigm is entrusted to market-driven principles, delineating a distinctive emphasis on the contributions of the private sector and local communities (Choi, 2016).

Both South Korea and Japan have adopted a shared approach in elderly care, with LTCI as the cornerstone of their policies. These frameworks prioritize home-based care over institutional alternatives and emphasize the significance of community care services. Importantly, both nations have implemented community care models to facilitate services delivery within the localities of the elderly population.

Japan has strategically dedicated concerted efforts towards addressing the challenges posed by an aging society within the realm of elderly welfare. The focal point of Japan's endeavors resides in the holistic well-being of the elderly demographic, underpinned by a steadfast commitment to the community-based management paradigm. A pivotal juncture in the manifestation of this commitment was notably observed with the implementation of LTCI in the year 2000, marking a substantive paradigmatic transition in Japan's approach to the domain of elderly welfare. Subsequent policy trajectories have manifested a discernible progression towards a prioritized emphasis on preventive therapeutic measures and seamless integration into the community fabric. This evolution is anchored in the establishment of a comprehensive community care system, which not only extends support for social services to the elderly population but also actively facilitates their pursuit of independent lifestyles within the local community. This multifaceted approach, in turn, contributes to the amelioration of the overall quality of life for elderly individuals in Japan.

In the case of South Korea, the nation's proactive engagement with the health and welfare of its aging populace predated its official entry into an aging society. Consequently, concerted efforts have been directed towards the expansion of community-based long-term care services and facilities tailored to meet the unique needs of the elderly. Such endeavors collectively strive to optimize health, proactively prevent afflictions, and enhance the overall quality of life for the elderly demographic.

Definition of Community Care

The genesis of the concept of community care can be traced back to its origin in the United Kingdom. Furthermore, in recent years, an array of related terminologies, such as community care, community-based care, aging in place, and aging in community, have gained prominence in academic and policy discourse. These terminologies have stimulated discussions across various fields, underscoring the paramount significance of the community's role and substantiating their persuasive merits. Nevertheless, the variegated definitions and versatile usage of the concept of commu-

nity in diverse contexts may engender confusion during the implementation of policies pertaining to community affairs.

For instance, the seminal work by Martin, W., & Wholihan, D. (1984) presented a foundational framework elucidating the concept of community care within the context of developing nations. The authors systematically scrutinized the conceptual underpinnings and policy nuances associated with community-based care (Martin, W., & Wholihan, D., 1984). Kane, R. L., Kane, R. A., & Ladd, R. conducted a comprehensive analysis, critically evaluating a tailored model of community care for the elderly population. Their examination underscored the paramount importance of fostering independence and elevating the overall quality of life through the strategic implementation of community care planning (Kane, R. L., Kane, R. A., & Ladd, R., 1998). Focusing on mental health services, Thornicroft, G., & Tansella, M. delved into the integration of community care. It provides practical guidance for enhancing mental health services within the community, emphasizing accessibility and effectiveness (Thornicroft, G., & Tansella, M.,2005). Oliver, M. contributed to the discourse by examining the social and political dimensions of disability, specifically in the context of community care's role in supporting individuals with disabilities(1990). It offers insights into the broader implications of community-based care within the disability discourse(Oliver, M., 1990). The Alma-Ata Declaration(World Health Organization, 1978) underscores the pivotal role of primary healthcare and community-based care as fundamental components of the global healthcare system. It advocates for the integration of community care into more comprehensive healthcare frameworks. Berrick, J. D., & Needell, B., addressed the intricate challenges and nuanced service needs inherent in community-based child welfare services. It sheds light on the complexities and considerations involved in delivering care to vulnerable children and families within a community setting(Berrick, J. D., & Needell, B., 1995).

As evidenced in the aforementioned research, the concept of community care manifests its expansive reach across diverse fields, underscoring its comprehensive and interdisciplinary nature.

There is a discernible trend toward the implementation of community-based elderly care programs in Japan, Korea, and Singapore. Nonetheless, a rigorous and substantive evaluation of policy effectiveness is warranted. This evaluative process should encompass critical components, including governmental budget allocation, the establishment of necessary local infrastructure, and the adequacy of the workforce responsible for delivering essential services. These facets represent pivotal elements in the orchestration of community-based care within nations that prioritize this paradigm.

This research endeavor is dedicated to undertaking an exhaustive analysis of the current status of elderly community care while concurrently venturing into prospective trajectories. In both the Japanese and South Korean contexts, a multifaceted array of initiatives and programs has been meticulously orchestrated, with a central pivot being LTCI

tailored to cater to the elderly demographic. Thus, this scholarly investigation will initiate its quest by delving into a comprehensive scrutiny of LTCI within the purview of both nations, subsequently navigating through the labyrinthine contours of Japan's regional comprehensive care system and South Korea's integrated community care model. However, it is paramount to underscore that this scholarly exposition will primarily revolve around an exhaustive examination of the LTCI paradigm. To effectively accomplish this overarching research objective, the study adopts a methodologically rigorous literature review approach, characterized by the meticulous and systematic scrutiny of reports, academic research papers, and pertinent documentation germane to the LTCI systems extant in both nations.

Method and Data Analysis

For this purpose, a comprehensive approach was employed, delving into reports, scholarly papers, and relevant publications associated with LTCI for the elderly in both nations. The intention was to systematically assimilate and comprehend the extensive corpus of existing literature through a meticulous process of reading, critical review, and analytical scrutiny.

The analysis of social welfare policies involves various methodologies, with the analytical framework developed by Gilbert and Specht being particularly prominent. Gilbert and Specht outline three primary categories for social welfare policy analysis: process analysis, product analysis, and outcome analysis (Neil Gilbert & Paul Terrell, 2014)

Policy analysis involves the systematic examination of the potential outcomes and impacts of policies, providing objective information to address issues encountered in the stages of policy formulation, decision-making, implementation, and evaluation.

Process analysis refers to an approach that examines the dynamics of social policy formation, focusing on social-political variables, as well as technical and methodological variables.

Performance analysis represents a systematic and impartial methodology employed in the evaluation of policies to scrutinize the consequences and effects arising from precise policy choices and program implementations. This analytical approach presents numerous advantages, including its objectivity, methodical observation, and capacity to furnish structured assessments of policy efficacy. Performance analysis hinges on empirical data, thus mitigating bias and subjectivity, and facilitating the discernment of both deliberate and unforeseen policy repercussions. In essence, it serves as a linchpin for evidence-based policymaking and the enhancement of public policies and programs.

Product analysis serves as a structured approach designed to comprehensively scrutinize the configuration and substantive content of policy choices encapsulated within policies oriented in a specific trajectory. This methodological approach is tailored to address foundational inquiries, encompassing questions into the character and intricate details of policy choices, the exclusion of alternative options

arising from these selections, and the foundational values, theoretical underpinnings, and assumptions that underlie these determinations. Product analysis is primarily centered on the deconstruction and elucidation of the elemental components inherent to policy design, with its principal emphasis placed on comprehending and distinguishing pivotal constituents within policy constructs. Diverging from process analysis, which investigates the fluid socio-political milieu of policy genesis, or performance analysis, which appraises policy outcomes, product analysis centers its inquiry on the intrinsic structure of policy decisions themselves (Gilbert & Terrell, 2005).

Gilbert and Terrell have introduced a conceptual framework for the examination of social welfare policies, employing the product analysis method as their analytical approach. They advocate that this method offers the advantage of impartiality by avoiding inherent bias toward particular value orientations while addressing a diverse array of issues. This methodological approach facilitates the systematic analysis of social welfare policies, accommodating a multifaceted spectrum of considerations, thereby rendering it an invaluable instrument for the rigorous analysis of public policies (Gilbert & Terrell, 2005).

Following the assertions put forth by Gilbert and Terrell (2005), the scrutiny of welfare policies necessitates an initial phase involving the explicit delineation of dimensions pertaining to choice. The quartet of dimensions proffered for policy analysis includes social allocation, benefits, delivery systems, and finance. It is posited that the morphological structure of welfare policies undergoes variation contingent upon these specified dimensions of choice.

In this research endeavor, we employ the analytical framework introduced by Gilbert and Terrell (2004)[(1)] as a foundational methodological apparatus for scrutiny. This analytical framework , commonly harnessed within the domain of social welfare analysis, encompasses four pivotal dimensions, namely: 1) Allocation, 2) Provision, 3) Delivery, and 4) Finance (Gilbert, N. & Terrel, P. 2014). These four analytical dimensions assume an indispensable role in the context of social welfare policy analysis, providing insights into the modality by which a specific policy, in the present context, LTCI system for the elderly, configures its benefit disbursement, identifies its societal beneficiaries, and orchestrates the financing and provisioning mechanisms. In essence, this framework facilitates a systematic and comprehensive examination and comprehension of the inherent eligibility requisites, benefit framework, service purveyors, and financial reservoirs intrinsic to such policies.

Consequently, we adhere to Gilbert and Terrell's analytical framework to undertake a comprehensive assessment of the elderly community care systems. Furthermore, this study inquiry endeavors to explicate the congruences and disparities inherent in the systems of the two respective nations, all the while engaging in deliberation on the outcomes and constraints of community-based care within both socio-political contexts.

Hence, in adherence to the analytical framework posited by Gilbert, N. & Terrel, P., this

study meticulously analyzes the mechanisms governing community care for elderly individuals in both nations. Additionally, it underscores the congruencies and disparities between the systems of the two countries while engaging in a discourse on the accomplishments and constraints of community care within both contexts.

In each analytical dimension, the study aims to investigate specific variables. Within the allocation dimension, the central inquiry pertains to determining who constitutes the beneficiary population. To address this, the research will initially conduct an exhaustive analysis of the beneficiaries covered by the LTCI systems in both Japan and South Korea.

Subsequently, the focus shifts to the dimension of benefits, which revolves around the essential question of what and to what extent do beneficiaries receive benefits. To comprehensively explore this dimension, the study will first dissect the typologies of benefits and then delve into an examination of the levels of benefits across various categories.

Furthermore, within the purview of the delivery systems dimension, the research endeavors to respond to the query,: how are services effectively delivered? This effort involves, firstly, examining the organizational structure of administrative and operational systems in both countries. Secondly, an in-depth analysis of the service utilization procedures in each nation will be undertaken.

Finally, the examination extends to the dimension concerning care personnel, with a specific focus on elucidating the status quo of service provider personnel and delineating the qualification prerequisites. In the financial dimension, the primary investigation pertains to addressing the question: how are financial resources secured for the LTCI system Within this financial domain, the research endeavors to assess the composition of funding sources for LTCI and ascertain the proportional contributions made by various stakeholders.

This study delineates a spatial focus on Japan and South Korea, a selection process necessitating careful consideration of several factors. Within the context of East Asian welfare states, notable mention is made of the family-centered welfare system (Uzuhashi 2003), illuminating the distinct cultural and historical backgrounds shared by Japan and South Korea vis-à-vis their European and American counterparts. Takegawa (2006) astutely observes South Korea's progression towards welfare statehood in both quantitative and qualitative dimensions, rendering it amenable to comparative analysis alongside Japan. The feasibility of comparative research hinges on the presence of congruencies in the developmental trajectories of institutional frameworks between the two nations. Despite temporal disparities, Japan and South Korea have traversed akin paths in responding to challenges emanating from the rapid aging of their populations and concurrent societal transformations.

Additionally, it is imperative to recognize the intricate interplay of influence among nations, wherein at least one nation exerts its impact upon another, as expounded by Kim (1997). Japan and South Korea have formulat-

ed LTCI policies in response to analogous social phenomena, characterized by demographic aging and escalating healthcare expenses for the elderly. Furthermore, the pioneering LTCI policy in Germany has exerted a discernible influence on the institutional frameworks of both Japan and South Korea. The configuration of Japan's LTCI system has also had a consequential impact on the structuring of South Korea's LTCI system. Japan and South Korea have formulated LTCI policies in response to analogous social phenomena, marked by demographic aging and escalating healthcare expenses for the elderly. Moreover, the pioneering LTCI policy in Germany has exerted a discernible influence on the institutional frameworks of both Japan and South Korea. Additionally, the configuration of Japan's LTCI system has imparted a consequential impact on the structuring of South Korea's LTCI system.

This research focuses on analyzing LTCI systems for the elderly in Japan and South Korea. Given the diverse policies within elderly welfare, each with unique forms of support, a comprehensive comparison of all policies is inherently challenging. Therefore, this study strategically examines LTCI frameworks in both nations, aiming to meticulously assess nuanced commonalities and distinctions. Additionally, the research explores the feasibility of implementing elderly community care, discussing institutional constraints in both countries and outlining the strategic trajectory. This scholarly effort serves as a foundational framework for the comparative policy evaluation between Japan and South Korea.

This paper aims to conduct an analytical exploration of the multifaceted dimensions underlying the four choices proposed by Neil. This endeavour holds the potential to serve as a foundational basis for constructing a comparative evaluative framework for policies operating within the intricate realms of Japan and Korea. In the domain of elderly welfare, numerous policies exist, each with distinct modes of support and systems, introducing challenges in directly comparing South Korea and Japan. Therefore, this paper specifically focuses on the LTCI systems of both countries.

The procedural process of determining eligibility for entitlements within the domain of social welfare policy is widely acknowledge as a pivotal factor in achieving the realization of policy objectives. Social welfare initiatives are strategically designed to address the needs of demographic segments expressing a requisition for assistance, utilizing societal resources and mechanisms to fulfil these requisites. Nevertheless, given the inherent constraints in societal resources, the precise and effective identification of cohorts with elevated demands for entitlements is recognized as a fundamental element in the achieving of policy objectives.

Allocation, briefly defined, is the systematic process of designating recipients for compensation. This involves identifying and verifying individuals who meet the criteria for entitlement. For instance, experts may assess the essential need for services on a case-by-case basis for individual beneficiaries, or rely on a careful evaluation of available financial re-

sources. Two primary paradigms within allocation are universalism and selectivity. Universalism asserts that, based on inherent societal rights, every individual qualifies as a beneficiary eligible for compensation, eliminating the need for further eligibility assessment. In contrast, selectivity relies on identifying beneficiaries through an income-based asset evaluation, particularly when their income falls below a predefined threshold. An evident example of this approach is found in public welfare frameworks such as the Basic Livelihood Security System, representing a prominent instance of a selective social welfare system.

Firstly, allocation pertains to the criteria and assurances governing the use of LTCI. Eligibility for long-term care services is primarily designated for individuals aged 65 and above who meet the specified criteria. Additionally, individuals under the age of 65 may qualify if they are affected by diseases typically associated with the elderly, as defined by law.

After identifying eligible beneficiaries for compensation, subsequent discussions naturally focus on the mechanisms through which the compensation framework will be disbursed to them. This discussion involves the modes of compensation delivery, considering whether compensation will be provided in monetary denominations, through non-monetary benefits, or via vouchers. Monetary disbursement mechanisms grant recipients autonomy, allowing them to optimize utility through participatory decision-making. Beneficiaries are empowered to allocate funds based on their specific needs and preferences, gaining control over financial inflows and participating in the decision-making process. However, this approach is not without limitations. For instance, when child allowances are monetarily disbursed, minors lack the legal capacity to autonomously manage their financial resources, introducing vulnerability where funds intended for the welfare of minors may be redirected by legal guardians for unintended or divergent purposes.

In the academic sphere, the term 'benefit in kind' refers to the provision of welfare services in the form of tangible commodities or services. This comprehensive definition encompasses instances such as offer providing medical services within the frameworks of arranging home visits through LTCI. While the utilization of benefit in kind mitigates resource inefficiencies by precisely targeting individuals with genuine needs, it is not immune to inherent limitations, notably the potential for generating a perceived stigma among recipients.

Vouchers can be considered as an intermediary approach positioned between cash-based and in-kind disbursement methods. Operating within predefined parameters, vouchers grant recipients the autonomy to choose their preferred services. Additionally, vouchers offer the advantage of fostering competition among service providers, potentially enhancing the overall quality of services.

The benefits officially approved within the LTCI for the Elderly mainly comprise in-kind benefits, with a nuanced inclusion of cash benefits under specific exceptional circumstances,

especially within the context of South Korea.

The concept of a delivery system is intrinsically tied to the agents accountable for the delivery process. In dispensing social welfare services, the responsible agents can be broadly categorized into the formal and informal sectors. Key components of the formal sector include the central government, local governmental entities, and organizations intricately involved in the administration of social welfare provisions. Conversely, the informal sector, often termed the private delivery system, encompasses entities such as Non-Profit Organizations (NPOs), Non-Governmental Organizations (NGOs), and philanthropic institutions.

Local governments, by virtue of their close interaction with residents, have the capacity to achieve a nuanced understanding of local needs, thereby facilitating service delivery that is potentially effective and efficient. Furthermore, competition among local governments may contribute to enhancements in service quality from the perspective of service recipients. However, inherent challenges emerge due to the relatively limited scale of local governments compared to the central authority, potentially leading to deficiencies in safety and sustainability within service programs.

In situations where the public sector encounters challenges in delivering services, individuals have the option to seek support from private social welfare entities. Implementing a private delivery framework can be perceived as yielding potential benefits, particularly in terms of cost containment within the government's social welfare expenditure and the enhancement of service quality through inter-organizational competition. Nevertheless, it is imperative to acknowledge that deficiencies in inter-agency collaboration impose limitations on the seamless provision of holistically integrated services.

Moreover, the scrutiny extends to the entities constituting the supply side in long-term care provision, encompassing facilities offering extended care services, domiciliary long-term care establishments, and the cadre of personnel devoted to long-term care, with a specific emphasis on care practitioners such as care aides.

The fourth pivotal dimension in the facilitation of support services pertains to the fiscal framework. After ascertaining the beneficiaries eligible for remuneration and instituting the mechanisms for its disbursal, a pivotal inquiry surfaces: By what means shall the requisite financial resources be procured? This quandary assumes paramount significance, representing a substantial challenge of global relevance transcending national borders. Notably, financial provisioning can be dichotomously classified into two primary domains: public funding and private funding.

In the context of facilitating service provisions, a fundamental consideration pertains to the financial infrastructure. Following the delineation of allocation, benefits, and delivery systems, the central inquiry revolves around the strategic acquisition of resources, constituting a paramount challenge and a predominant focus across nations. Funding mechanisms are classified into two broad categories: public resources and private resources.

Initially, it is imperative to acknowledge that the domain of general taxation, particularly within the context of income taxation, operates under a progressive levy mechanism. This mechanism dictates that individuals with higher income levels are subject to elevated tax rates, as illustrated by the application of income tax. In contrast, the realm of indirect taxation, while advantageous due to its expeditious revenue collection facilitated by reduced taxpayer resistance, presents a concurrent drawback whereby an increase in its relative proportion tends to diminish the effectiveness of income redistribution. Particularly salient in this discourse is the domain of consumption taxes, exemplified by the value-added tax (VAT). In this system consumers, upon procuring commodities, indirectly remit taxes through the inclusion of a tax component in the commodity price, thereby generating a revenue stream for public treasuries.

The subsequent consideration pertains to social insurance contributions, which inherently demonstrate a inclination for proportional assessment, in accordance with income levels and are infused with intentional design. This signifies a form of taxation guided by its inherent purposiveness, where in the tax revenue generated is allocated for well-defined objectives, characterized by transparency and explicit allocation, thereby yielding discernible merits. Illustrative examples encompass the realm of medical insurance and pension schemes, emblematic of the specialized nature of taxation directed towards distinct purposes.

In the domain of acquiring financial resource for support services, it is imperative to acknowledge the presence of private funding sources, including user fees and voluntary contributions. User fees involve the financial responsibility placed on recipients of welfare services, serving a dual purpose as both a means of cost-sharing and a deterrent against potential service misuse. This mechanism, compelling users to bear a portion of the service costs, promotes fiscal responsibility and, theoretically, mitigates frivolous utilization.

Lastly, within the purview of the Elderly LTCI Act, the concept of the delivery system encompasses a set of systems prescribed by the legislation, intricately linked with service access and utilization processes. This encompasses a series of procedural steps, including the submission of service applications to the National Health Insurance Corporation, the administrative functions executed by the Corporation's long-term care managers, which encompass the assessment and classification of individuals, negotiation and execution of contracts with service-providing institutions, and the subsequent utilization of services by eligible beneficiaries. Likewise, this dimension entails the delineation of authorities and responsibilities within the National Health Insurance Corporation, including those vested in its long-term care managers, in addition to the engagement of service-providing institutions and their personnel. All these constituent elements play pivotal roles in ensuring the efficient operation of the delivery system.

Findings

1. Allocation

In Japan's LTCI system, insurers are primarily local government entities, specifically cities and towns, including the special wards of Tokyo, which comprise a total of 23 wards. These entities are responsible for collecting insurance premiums and undertaking essential tasks such as care eligibility assessment. Moreover, insurers supervise diverse functions, including managing the qualifications of insured individuals, imposing and collecting insurance levies, assessing care needs, disbursing insurance benefits, and overseeing fiscal operations.

In the context of South Korea's LTCI system, the operational framework is divided into four principal entities: 1) the Ministry of Health and Welfare, 2) local government bodies, 3) the National Health Insurance Corporation (NHIC), and 4) long-term care facilities (commonly referred to as service providers). Oversight and management of the long-term care insurance system are centralized within the Ministry of Health and Welfare at the national level. Local government entities at the municipal and county levels assume responsibility for infrastructure development and the provision of guidance and supervision to service providers. The NHIC, on the other hand, is tasked with a wide spectrum of responsibilities related to the system, as well as its comprehensive administration.

Japan's long-term care insurance system classifies insured individuals into two groups: 1) First-category insured individuals who are residents aged 65 and above and live within municipalities, and 2) Second-category insured individuals who are residents aged 40 to 64 with medical insurance coverage and also reside within municipalities. These two groups have different entitlements, meaning they have varying access to insurance benefits, responsibilities for insurance premiums, and methods of payment. In this system, beneficiaries are determined as follows: First-category insured individuals become eligible for insurance benefits when they are certified as needing care or support, regardless of the specific cause. Second-category insured individuals, on the other hand, can receive insurance benefits only if they require care due to certain aging-related conditions like stroke, early-stage dementia, and cerebrovascular disorders, which are part of a list of 16 specific diseases. Table 1 outlines the criteria used for certification in Japan's long-term care insurance system.

In the framework of South Korea's long-term care insurance system, beneficiaries are identified as individuals aged 65 years and older, as well as those affected by age-related illnesses. Insured individuals, similar to those eligible for health insurance, comprise the entire national population and are obligated to make insurance premium contributions. The classification criteria for beneficiaries are determined based on the long-term care certification points, leading to a six-tier classification system. Table 2 provides as an informative illustration of the certification criteria utilized South Korea's LTCI system.

Table 1 Criteria Information for Long-Term Care Eligibility Assessment in Japan

Assistance Level 1	A state where one can perform most of the activities of daily living independently but requires some support for instrumental activities of daily living	25 ≤ minutes < 32
Assistance Level 2	A condition where one can perform most of the activities of daily living independently but requires some support for instrumental activities of daily living	25 ≤ minutes < 32
Nursing Care Level 1	A state where one can perform most of the activities of daily living independently but requires some form of support for instrumental activities of daily living	32 ≤ minutes < 50
Nursing Care Level 2	A state where the ability to perform activities of daily living is slightly diminished compared to 'requiring support level 1'	50 ≤ minutes < 70
Nursing Care Level 3	A state where there is a significant decline in both basic activities of daily living and instrumental activities of daily living, requiring almost full-time caregiving	70 ≤ minutes < 90
Nursing Care Level 4	A state where the functional capacity has further declined from the condition requiring level 3 caregiving, making it difficult to carry out daily life without assistance.	90 ≤ minutes < 110
Nursing Care Level 5	A state where the functional capacity has further declined from the condition requiring level 4 caregiving, making it almost impossible to perform daily life activities without assistance.	More than 110 minutes

Sources: Created with reference to the Ministry of Health, Labour and Welfare website. Accessed in September 2023.

Table 2 Criteria Information for Long-Term Care Eligibility Assessment in South Korea

Ranking 1	A person who is completely dependent on the help of another person to go about daily life	score ≥ 95
Ranking 2	A person who is mostly dependent on the help of another person to go about daily life	75 ≤ score < 95
Ranking 3	A person who is in partial need of the help of another person to go about daily life	60 ≤ score < 75
Ranking 4	A person with mental and physical disabilities and who is in partial need	51 ≤ score < 60
Ranking 5	A person with dementia	45 ≤ score < 51
Cognitive Support Ranking	A person with dementia	Below 45

Sources: Casebook of Senior Long-Term Care Insurance Consultations for the Year 2023. Chapter 2: Long-Term Care Assessment and Classification. Accessed in September 2023.

Table 3　Number of Certified Long-Term Care Beneficiaries in Japan(thousand person)

	Insured Number	Assistance Level 1	Assistance Level 2	Nursing Care Level 1	Nursing Care Level 2	Nursing Care Level 3	Nursing Care Level 4	Nursing Care Level 5	2020	2015	2010
Total	6,968	990	963	1,451	1,165	922	885	592	6,818	6,204	5,062
Class 1 Insured	6,837	978	943	1,430	1,139	903	868	576			
Class 2 Insured	131	12	20	21	27	19	16	16			

Sources: Created on the Ministry of Health, Labour and Welfare's Monthly Report on the Status of Long-Term Care Insurance Services from 2000 to 2022.

Table 4　Number of Certified Long-Term Care Beneficiaries in Korea

Insured Number	Ranking 1	Ranking 2	Ranking 3	Ranking 4	Ranking 5	Cognitive Support Ranking	2020	2015	2010
1,019,130	49,946	94,233	278,520	459,316	113,842	23,273	1,183,434	792,092	465,777

Sources: Created on the National Health Insurance Corporation's Major Statistics of Long-Term Care Insurance from 2009 to 2022.

This investigation examines the evolutionary trends in certification within the Japanese LTCI system. Established in the year 2000, the certification figures in 2001 stood at 2,884,063, subsequently experiencing a significant surge to 6,968,160 by the end of 2022. Categorically, Types 1 and 2 collectively account for 28% of the overall certification spectrum, while Types 1 through 5 encompassing the remaining 72%. Notably, Type 1 constitutes approximately 21%, representing the highest proportional representation in long-term care certification (refer to Table 3). This ratio has consistently maintained the same magnitude.

Following, this research undertake an inquiry with the intention of meticulously examining the dynamic composition of certified individuals within the specific context of South Korea. As of the year 2022, the cumulative tally of certified participants registered under South Korea's LTCI initiative stands at an impressive 1,019,130. This assemblage can be further delineated into distinct strata as follows: a cohort of 49,946 individuals in the Grade 1 category, 94,233 individuals classified under Grade 2, a sizable contingent of 278,520 individuals designated as Grade 3, a substan-

tial cohort of 459,316 individuals falling within the purview of Grade 4, and a contingent of 113,842 individuals who find categorization under Grade 5. Moreover, a notable subset comprising 23,273 individuals attains certification under the cognitive support level. Significantly, it warrants attention that the amalgamated proportion of Grade 1 and Grade 2 certified individuals, relative to the entirety of the certified population, stands at 14.1%. In contrast, Grade 3 and Grade 4 certified individuals, when considered in concert, collectively constitute 27.3% of the overall certified population. Furthermore, it is germane to underscore that aged individuals beset by dementia, necessitating a heightened degree of care, are disseminated across Grade 5 and the cognitive support level, collectively constituting 13.5% of the certified population. In the case of certified individuals in South Korea, it becomes conspicuously evident that a substantial majority, exceeding the threshold of 56%, can be characterized as severe cases within the elderly demographic.

Both nations have demonstrated an upward trajectory in the number of applicants and certified individuals. In the case of Japan, there has been a notable increase, exceeding twofold, from 2,884,063 individuals in 2001 to 6,968,160 individuals in 2022. Similarly, in South Korea, during the early stages of program implementation in 2009, the figures surged from 286,907 individuals to 1,019,130 individuals by 2022, signifying an approximately 3.5-fold increment. It is pertinent to underscore that both countries have consistently observed an annual augmentation in the certification rate among the elderly populace.

2. Provision

Within the framework of Japan's LTCI program, there are distinct categories of benefits, namely long-term care benefits (intended for individuals requiring long-term care), preventive benefits (targeted at individuals necessitating care support), and municipality-specific special benefits administered by local authorities (caring to both individuals in need of long-term care and those requiring care support)[(2)].

Within the framework of the LTCI system, there exists a deliberate specification of services eligible for benefits. These services are systematically categorized into two primary domains: home-based services and facility-based services. Nevertheless, a pivotal juncture in the evolution of the system occurred with the introduction of a novel component, namely preventive benefits, as delineated in the 2005 revision of the Long-Term Care Insurance Act. Home-based services encompass a range of supportive interventions aimed at enabling individuals to lead their daily lives while remaining in the familiar setting of their homes. This category encompasses services provided by home helpers and day services. Conversely, facility-based services pertain to individuals who reside in dedicated care facilities, such as special nursing homes for the elderly or elderly health care facilities. In these settings, recipients receive a spectrum of care services, including assistance with fundamental activities such as meal preparation and bathing. Additionally,

facility-based services extend to encompass other facets of daily life support, rehabilitation, and comprehensive medical care. The core concept underpinning long-term care prevention centers around a proactive approach to mitigating the risk of elderly individuals becoming dependent on long-term care. This entails not only averting the onset of conditions necessitating long-term care but also maintaining or enhancing the well-being of individuals once they are classified as needing care. This multifaceted benefit structure harmonizes with the foundational principles of the LTCI system. Central to these principles is a deep-seated commitment to honoring the dignity and autonomy of elderly individuals, while concurrently facilitating their capacity to lead autonomous lives to the greatest extent possible.

The LTCI system in South Korea extends facility and home-based services to qualified beneficiaries eligible for LTCI benefits. The modalities of these services exhibit similarities with the corresponding provision in Japan. Furthermore, in the South Korean context, a specialized cash benefit system is selectively implemented, particularly in cases pertaining to individuals encountering challenges in accessing services due to residency in remote locales or on islands.

3. Delivery

Let us delve into an examination of the entities responsible for delivering LTCI services. In Japan, home-based services are available to various providers, given they meet specific criteria, irrespective of their organizational classification. On the other hand, establishments providing institutional care services, referred to as facilities, can only be established by designated entities, including local public entities, medical corporations, and social welfare corporations[(3)]. It is worth noting that the establishment of paid nursing homes, carried out by for-profit corporations like joint-stock companies, may be subject to regulatory limitations imposed by individual municipalities.

The primary actors involved in the delivery of LTCI services include care managers, long-term care welfare workers, and home helpers. Care managers shoulder various responsibilities, serving as intermediaries for nursing certification applications, conducting through home visits for certification assessments, crafting individualized care plans, and offering consultations to insured individuals and their families. In their leadership role, care managers engage in investigative efforts to assess the conditions of those requiring care, organize meetings with service personnel, coordinate with diverse service providers, and facilitate consensus-building with insured individuals and their families. Among these responsibilities, the formulation of care plans stands out as a central aspect of care management, requiring a profound understanding of specialized service knowledge. Care managers are crucial in this capacity, mandated to maintain a judiciously equitable and neutral demeanor, while respecting the autonomy of service users, safeguarding their rights, and adhering to principled standards of impartiali-

ty.

In June 1987, Japan institutionalized the profession of Certified Care Worker as a nationally recognized qualification under the Social Welfare Worker and Certified Care Worker Act. This designation marked a significant development in the realm of caregiving, and the role of Certified Care Workers has solidified within the caregiving landscape, particularly in conjunction with the implementation of the LTCI system. These professionals bring specialized knowledge and expertise to the caregiving sector. The core responsibilities of Certified Care Workers revolve around delivering services to individuals who face impediments in their daily lives due to physical or mental challenges. These services encompass a wide spectrum, including bathing, toileting, and meal assistance. Additionally, Certified Care Workers play a crucial role in offering guidance and instruction related to caregiving, addressing the needs of both care recipients and caregivers alike. In parallel, Japan has established a certification system for Home Helpers, with two distinct levels denoting their qualifications and responsibilities. Home Helper Level 2 primarily focuses on providing support for household tasks and a broad range of physical activities. In contrast, Home Helper Level 1 assumes a more comprehensive role, extending beyond household support and physical activities to include responsibilities such as serving as the designated personnel responsible for providing visitation caregiving services. These qualifications and roles within the caregiving sector underscore Japan's commitment to addressing the evolving needs of its aging population and ensuring the provision of high-quality care services in both home and institutional settings.

In South Korea, the landscape of LTCI agencies can be broadly segmented into two distinct categories based on the types of benefits they provide: those caring to facility-based services and those specializing in home-based services. Referred to as institutional-based facilities in the context of South Korea, elderly care facilities function as dedicated institutions designed to accommodate elderly individuals who have encountered significant physical and cognitive impairments due to conditions such as dementia, cerebrovascular diseases (akin to strokes in Japan), or other age-related illnesses. These individuals require substantial assistance in their day-to-day activities and living arrangements. The primary objective of these facilities is to offer a comprehensive range of services, encompassing meal provision, medical care, and various other forms of essential support to address the daily needs of their residents. To qualify as LTCI agencies capable of providing home-based benefits in accordance with the Elderly Long-Term Care Insurance Act, institutions must adhere to rigorous standards for both their physical facilities and personnel. These standards are established to ensure the provision of high-quality care services in home settings. Institutions seeking to offer home-based benefits must submit formal applications for establishment to the respective municipal authorities, including city, county, or district offices. This process involves compliance with the specific regulations govern-

Table 5　Transition of Long-Term Care Service Facilities and Facilities in Japan

Benefits	2009	2011	2013	2015	2017	2019	2020	2021	2022
Number of Institution-based Benefits	2,629	4,061	4,871	5,085	5,304	5,543	5,763	5,988	6,150
Number of Home-based Benefits	11,931	10,857	11,672	12,917	15,073	19,410	19,621	20,559	21,334
Total	14,560	14,918	16,543	18,002	20,377	24,953	25,384	26,547	27,484

Sources: Created by the Ministry of Health, Labour and Welfare of Japan, National Institute of Population and Social Security Research from 2000 to 2022.

ing home-based care insurance agencies and adherence to the prescribed facility and personnel criteria.

The primary workforce responsible for delivering essential caregiving services in South Korea revolves around a category known as home helper, a role roughly equivalent to home helpers in the Japanese context. The term home helper encompasses individuals who provide critical physical and household support services, specifically aimed at elderly individuals who encounter significant impediments in maintaining independent daily living due to age-related ailments. These professionals operate within the framework of elderly care facilities and home care centers, addressing to the diverse needs of their clientele (Ministry of Health and Welfare, 2013). To qualify as a certified home helper, individuals must successfully complete an educational program offered by accredited institutions and subsequently pass a qualification examination.

Table 5 illustrates the temporal dynamics in the landscape of long-term caregiving service providers and facilities within the Japanese context. The inception of the LTCI system in the year 2000 marked the presence of 10,992 facilities, which incrementally expanded to reach a count of 12,139 by the year 2004. A subsequent period spanning from 2006 through 2010 witnessed a discernible contraction in the number of facilities. However, commencing in 2011, a resurgent growth pattern took hold, culminating in an augmented tally of 13,731 facilities by the year 2021. In stark contrast, domiciliary service establishments exhibited a notable proliferation, surpassing a twofold increase, surging from 59,482 in 2000 to a remarkable 125,056 in 2008. Concomitantly, caregiving preventative and home-based service providers made their debut in the landscape in 2006, entering with 87,491 establishments, and subsequently underwent substantial expansion, achieving a count of 158,128 by 2017. However, a precipitous decline ensued in 2020, resulting in a contraction to approximately 85,657 establishments, and this trajectory has persisted.

Table 6 delineates the temporal trajectory of LTCI facilities and home-based service establishments in South Korea. As evidenced by

Table 6 Transition of Long-Term Care Service Facilities and Facilities in Korea

Benefits	2000	2002	2004	2006	2008	2010	2011	2014	2017	2020	2021
Number of Institution-based Benefits	10,992	11,645	12,139	12,036	11,767	10,828	11,197	12,865	13,409	13,702	13,731
Number of Home-based Benefits	59,482	73,513	93,051	118,412	125,056	123,645	128,446	192,132	205,324	206,177	208,634
Number of Home Care Prevention Services				87,491	97,014	96,672	100,497	149,109	158,128	85,657	87,182
Total	70,474	85,158	105,190	217,939	233,837	231,145	240,140	354,106	376,861	305,536	309,547

Sources: Created on the National Health Insurance Service from 2008 to 2022.

the numerical data, both facility-based entities (increasing from 2,629 in the fiscal year 2009 to 6,150 by the fiscal year 2022) and domiciliary service providers (rising from 11,931 in the fiscal year 2009 to 21,334 by the fiscal year 2022) have demonstrated a sustained trend of augmentation. It is noteworthy that the surge in home-based institutions has been particularly pronounced.

4. Finance

The primary focus of analysis revolves predominantly around the financial aspects of the Elderly LTCI program, involving a thorough examination of its fiscal standing and operational intricacies. Currently, the National Health Insurance Corporation holds pivotal responsibilities within the scope of the Elderly Long-Term Care Law, particularly regarding the imposition and collection of insurance premiums, along with the overall fiscal governance of the program.

In Japan, the financing structure of the LTCI system is relies on a multifaceted approach that includes public funding, insurance premiums collected from policyholders, and user contributions. Specifically, 10% of the required financial pool for caregiving benefit disbursement comes from individual user self-payments, while 45% is supported by public fiscal allocations. This allocation of public funding is divided into support from the national government, with 22.5% from the central government and 22.5% from local governments. The remaining 45% is sourced from insurance premiums, shared by the citizenry, with one-third from primary insured individuals and two-thirds from secondary insured individuals. However, it is important to note that after the 2015 overhaul of the LTCI system, the previously fixed user self-payment rate of 10% underwent a modification. For individuals certain income brackets, this rate increased to 30%.

The financial foundation of South Korea's

Table 7　Performance of Long-Term Care Insurance Benefits in Japan(1,000,000 yen, %)

	2005	2008	2012	2015	2018	2021	2022
Total	455,227	523,047	664,057	72,836	77,957	84,144	98,467
Cost of Home-based benefits	248,426	263,080	357,793	40,237	39,056	42,499	49604 (50.4%)
Cost of Institu-tion-based benefits	206,801	216,008	236,593	23,959	25,575	27,178	31938 (32.4%)
Cost of Commu-nit-based benefits		43,959	69,670	8,640	13,326	14,467	16925 (17.2%)

Sources：Created on the Ministry of Health, Labour and Welfare of Japan. 2000～2022.

LTCI system involves contributions from caregiving insurance premiums, governmental subsidies, and individual expenditures. A more detailed examination of each aspect reveals that initially, contributors to caregiving insurance premiums align with those in the health insurance domain, encompassing both workplace and community participants[(4)]. The state-owned entity integrates and collects caregiving and health insurance premiums, with caregiving insurance premiums calculated by applying the caregiving insurance premium rate to the amount of health insurance premiums. The determination of the caregiving insurance premium rate follows a deliberative process conducted by the Long-Term Care Committee[(5)] and is formalized through presidential decree. Furthermore, governmental involvement materializes through an annual allocation within the confines of budgetary constraints, amounting to 20% of the anticipated revenue derived from caregiving insurance premiums for the fiscal year in question. Individual contributions, on the other hand, encompass a partial cost-sharing mechanism, with individuals bearing a 15% burden of caregiving insurance benefit expenses in the context of home-based benefits and a 20% obligation in the case of facility-based benefits.

Table 7 delineates the empirical data on disbursements within Japan's long-term care insurance. This dataset is categorically divided into three primary domains: disbursements allocated to institutional care, those earmarked for home-based care, and those channeled into community-based services. The cumulative disbursements across these three distinct categories in the fiscal year 2022 amounted to an impressive 9,846.7 billion yen.

Table 8 provides an overview of the operational outcomes of long-term care insurance benefits in the context of South Korea. These benefits are categorized into two primary groups: facility-based provisions and home-based provisions. The cumulative expenditure attributed to long-term care within the frame-

Table 8 Performance of Long-Term Care Insurance Benefits in Korea (100 million won, %)

	2015	2017	2018	2019	2020	2021	2022
Total	39,816 (100)	50,937 (100)	62,992 (100)	77,363 (100)	88,827 (100)	100,957 (100)	114,441 (100)
Cost of Home-based benefits	19,376 (48.66)	26,417 (51.86)	34,344 (54.5)	43,702 (56.5)	52,302 (58.9)	61,917 (61.3)	70,977 (62.0)
Cost of Institution-based benefits	20,441 (51.33)	24,520 (48.13)	28,648 (45.5)	33,661 (43.5)	36,525 (45.5)	39,040 (38.7)	43,465 (38.0)

Sources: Created on the National Health Insurance Service from 2008 to 2022.

Table 9 Trends in Long-Term Care Insurance Premiums in Japan (Japan Yen)

Phase	Insurance Premium (National Average)
the1st Phase (2000 ～ 2002)	2,911
the2nd Phase (2003 ～ 2005)	3,293
the3rd Phase (2006 ～ 2008)	4,090
the4th Phase (2009 ～ 2011)	4,160
the5th Phase (2012 ～ 2014)	4,972
the6th Phase (2015 ～ 2017)	5,514
the7th Phase (2018 ～ 2020)	5,869
the8th Phase (2021 ～ 2023)	6,014

Sources: Ministry of Health, Labour and Welfare of Japan, National Institute of Population and Social Security Research from 2000 to 2022.

work of the insurance program amounted to KRW 11,441 billion, reflecting a notable increase of 13.4% in the fiscal year 2022 compared to the previous year.

Table 9 illustrates the trajectory of LTCI premiums in Japan. The LTCI program adopts a segmentation approach, dividing its operational periods into intervals of three years since its initiation. Remarkably, the premiums, which were at 2,911 yen during the inaugural phase (2000-2002), have increased to 6,014 yen in the eighth phase (2021-2023), indicating a more that twofold escalation compared to the initial phase.

Table 10 presents the longitudinal trajectory of LTCI premiums in the context of South Korea. Precisely, the premiums were 5,132 won in 2011, experiencing a slight increase to 5,520 won in 2013 with marginal discrepancies. However, a significant augmentation become apparent when examining the per capita perspective. Individual-level premiums nearly doubled, rising from 1,277 won in 2009 to 2,516 won.

Table 10　Trends in Long-Term Care Insurance Premiums in Korea(Korea Won)

	2011	2013	2018	2019	2020	2021	2022	Rate of Change(%) Year-over-Year
Average Insurance Premium per Household	5,132	5,520	7,599	9,191	11,511	13,892	15,740	13.3
Average Insurance Premium per Person	2,192	2,516	3,718	4,655	5,976	7,413	8,654	16.7

Sources: National Health Insurance Service from 2008 to 2022.

Discussion

The introduction of LTCI for the elderly can be construed as a strategic response to the ongoing global demographic transformation characterized by the increasing proportion of the aging population. This policy framework is intentionally designed with a dual objective: to improve the health and overall well-being of individuals during their later life stages and, simultaneously, to alleviate the caregiving responsibilities borne by families. Importantly, this policy paradigm has been implemented in various nations, including Germany, Japan, South Korea, and others.

The main goal of this study is to conduct a thorough comparative analysis of the LTCI schemes for the elderly in South Korea and Japan. Both countries implement long-term care services for elderly citizens through similar social insurance systems. In the context of this comparative analysis, the study aims to closely scrutinize the potential and feasibility of community-based care for elderly individuals in these two nations.

To achieve this overarching objective, the study utilized the analytical framework developed by Gilbert and Terrell within the realm of social welfare. Employing this framework, a comprehensive analysis is conducted, addressing four crucial dimensions- allocation, provision, delivery, and finance- that characterize and uphold the elderly LTCI programs in both countries.

In 2000, Japan initiated the implementation of its LTCI program, for the aging population, and subsequently, South Korea formulated and implemented a comparable policy in 2008. During the policy formulation phase, Japan drew upon the institutional framework of Germany's long-term care system, while the conceptualization of South Korea's LTCI system incorporated insights from the systems of both Germany and Japan. Both nations, South Korea and Japan, strategically positioned their respective LTCI programs within the broader context of social insurance systems. Additionally, given the intricate interplay of policy influences and cross-national learning, the LTCI programs in Japan and South Korea have become recurring focal points for comparative research within the broader landscape of

LTCI policies.

This study represents an initial foundational effort aimed at examining the landscape of community-based care for the elderly in both nations. Utilizing Gilbert and Terrell's comprehensive framework for the analysis of welfare policies, a thorough comparative examination of the constituent policy elements within each nation was diligently conducted. The primary objective of this analytical endeavour is to stimulate substantive discourse regarding the viability and future outlook of community-based care within the unique contexts of both countries.

This study undertook a thorough evaluation of the operational policies supporting community-centric elderly care, a pivotal paradigm in both Japan and South Korea, by examining their respective LTCI systems. The analysis, centered on essential components such as financial resources, service delivery mechanisms, infrastructural elements, and the workforce engaged in service provision, aimed to scrutinize and assess the critical determinants in the implementation of community-based care. Through a comparison and dissection of the LTCI frameworks of both nations, this research illuminated the current landscape of community care and provided several salient insights concerning prospective trajectories.

While the LTCI programs in Japan and South Korea share congruent overarching objectives and institutional frameworks, they also exhibit discernible disparities rooted in the idiosyncratic contextual factors inherent to each nation. The following provides a comprehensive elucidation of the distinctions between the systems in these two countries.

1. Allocation

To further explore the policy disparities between South Korea and Japan, it is essential to closely examine the allocation component. In South Korea, the LTCI program embraces a universal approach, categorizing insured individuals similarly to those enrolled in health insurance schemes. Consequently, it mandates LTCI coverage for the entire population, extending its reach to all citizens. In contrast, Japan adopts a more nuanced approach by distinguishing between primary insured individuals, referred to as First Insured Persons, and secondary insured individuals, designated as Second Insured Persons. First Insured Persons encompass citizens aged 65 or older, whereas Second Insured Persons include individuals aged 40 or older who exhibit specific medical conditions . This marked contrast in eligibility criteria highlights Japan's more selective approach in contrast to South Korea's universal enrolment policy.

In the context of LTCI, Japan and South Korea both adhere to the principles of universality in service provision. These systems are intentionally designed to cater to a specific demographic, primarily individuals aged 65 and above. The allocation of LTCI benefits, along with the determination of eligibility for these benefits, is primarily contingent upon age and specific medical conditions. Consequently, achieving comprehensive coverage for all segments of the population in need of long-term care services remains an elusive

goal. Therefore, it is appropriate to characterize the LTCI systems of both nations as possessing a restrictive nature in terms of user accessibility.

When considering the implementation of these programs, it is essential to note the differences in eligibility criteria between Japan and South Korea. Japan's LTCI program is designed for individuals aged 40 and above who are part of the medical insurance system. In contrast, South Korea's program has no age restrictions and encompasses a broader range of age groups, including individuals who contribute to the health insurance system. This variation in eligibility criteria reflects the differing approaches and demographic considerations in the LTCI systems of the two countries.

In Japan, the eligibility criteria for insurance enrolment encompass all participants in the National Health Insurance system, maintaining inclusivity as a fundamental principle. However, the criteria for receiving long-term care benefits are more stringent, involving factors such as age limitations and specific disease criteria, resulting in a notable discrepancy between the social insurance burden and the principle of equity. Additionally, the actual utilization of long-term care services by elderly individuals in Japan is limited to a subset of the elderly population. While various factors contribute to this restricted access, the primary reason is the rigorous criteria employed in the selection of eligible beneficiaries, often associated with fiscal constraints. Notably, Japan took measures to expand the scope of beneficiaries for preventive benefits and community-based services starting from five years after the introduction of the LTCI system in 2006. In contrast, South Korea has grappled with a similar issue of limited beneficiaries since the early stages of program implementation. To address this concern, the Ministry of Health and Welfare restructured the grading system in July 2014, transitioning from a three-tier system to a five-tier system, to increase the number of beneficiaries (Ministry of Health and Welfare, 2014). This transition is expected to result in more extensive coverage of individuals in need of long-term care services, aligning more closely with the universal principles of social insurance.

From a financial standpoint, the collection of insurance premiums significantly impacts the fiscal stability of the LTCI system. However, policyholders themselves face a challenge where, due to the restricted scope of eligibility, they receive minimal benefits in practice and primarily bear the burden of insurance premiums. The right to access services is not guaranteed for policyholders unless they receive certification. Additionally, the failure to pay insurance premiums also results in the forfeiture of the right to use services. Consequently, when low-income individuals are unable to pay insurance premiums, they may be deprived of the right to access services. In Japan, although there was a reduction in the upper limit of insurance premiums for low-income individuals following a revision in 2005, it is essential to contemplate additional support measures beyond premium reduction, considering that a significant number of certified individuals do not actually utilize the ser-

vices. Both countries restrict the target demographic of beneficiaries; however, there is a distinction in the age groups encompassed. Japan includes individuals aged 40 and above, whereas South Korea extends coverage to those aged 20 and above. This disparity has the potential to generate intergenerational conflicts.

The LTCI frameworks in Japan and South Korea share a common overarching objective of providing universal services, coupled with distinct constraints. Both nations primarily target individuals aged 65 and older for service provision, albeit with nuanced variations. In the South Korean context, the initial approval rate demonstrated a notably lower magnitude at the system's inception. Subsequently, there has been an observable increase in the number of certified individuals. Nevertheless, relative to nations offering similar elderly care services, South Korea's certification rate remains comparatively modest. This intentional moderation in the certification rate stems from a strategic effort to control costs, albeit resulting in the exclusion of elderly individuals requiring mild care. This aspect underscores the potential for financial constraints to hinder insurance subscribers in both countries from fully realizing the benefits, thereby complicating service utilization for the low-income demographic.

Japan, in its commitment to alleviating insurance premiums for individuals of lower socioeconomic status, grapples with the persistent challenge of escalating premiums. Another notable issue pertains to the multi-generational contribution to premium payments, while eligibility for actual services is restricted to individuals aged 65 and older. This incongruity holds the potential to generate intergenerational conflicts. In summary, while Japan and South Korea are at the forefront of providing LTCI to their elderly populations, constraints in service availability and utilization primarily arise from age-centric restrictions, eligibility criteria, and intricate financial considerations.

2. Provision

The secondary dimension concerns the nature of benefits. The fundamental types of benefits in both nations exhibit a degree of similarity. Specifically, these encompass home-based benefits and facility-based benefits, with a prioritized emphasis on the provision of home-based benefits designed to facilitate independence within a more familiar setting.

Japan's LTCI program offers a more extensive array of benefits, comprising home-based care benefits, three categories of facility-based care benefits, and supplementary region-specific services tailored to meet unique local needs. This comprehensive suite of benefits reflects the nuanced approach adopted by Japan to cater to the diverse care requirements of its elderly population.

Both Japan and South Korea have implemented comprehensive LTCI systems that encompass various forms of care, primarily focusing on in-home and facility-based services. However, a significant divergence in the benefit structure between the two countries emerges in the inclusion of special cash benefits in

South Korea's system, whereas Japan adheres exclusively to in-kind benefits within its LTCI framework. This distinctive approach deviates from the choices made by countries like South Korea and Germany, which have also adopted a social insurance model but offer a combination of both in-kind and cash benefits.

In general, in-kind benefits are characterized by restrictions on recipients' choices but are often viewed favorably for their effectiveness and efficiency in meeting the specific needs of targeted population segments. Conversely, cash benefits are appreciated for affording recipients greater autonomy and promoting extended independence. However, the equitable distribution of cash benefits can pose challenges, potentially leading to unequal access to services. On the other hand, in-kind benefits may inadvertently contribute to stigmatization.

The special cash benefits in South Korea are categorized into family care expenses, special care expenses, and hospital care expenses. Family care expenses are allocated to recipients receiving substantial caregiving services from family members. Nevertheless, concerns have been raised regarding the non-specialized expertise of family caregivers, and as of 2014, the beneficiaries in this category remain limited, constituting a mere 0.2% of the total cases.

The resistance from numerous women's advocacy groups during the initiation of LTCI in Korea against the incorporation of cash benefits was rooted in the apprehension that the introduction of cash benefits would inevitably position women within households as the principal providers of home-based services, potentially impeding their social progress. In the Korean context, although the fundamental principle is centered on in-kind benefits, there is a partial acknowledgment of cash benefits through the implementation of special cash benefits.

Furthermore, there are distinctions between the two nations concerning individual cost-sharing responsibilities. Both countries incorporate individual out-of-pocket contributions for benefit utilization. Japan imposes a variable individual cost-sharing ranging from 10% to 30%, implementing a high-cost medical expense service to mitigate the risk of exorbitant out-of-pocket burdens. Conversely, South Korea applies a 20% co-payment for facility-based benefits and a 15% co-payment for home-based benefits.

Moreover, significant distinction in benefit structures between the two nations lies in their stance regarding the recognition of cash benefits. Japan rigidly upholds the principle of providing benefits in kind and does not acknowledge the provision of cash benefits. This policy orientation stems from concerns that the introduction of cash benefits might inevitably lead to a scenario where women within households become the primary caregivers for home-based care services, potentially impeding their societal participation. Consequently, during the initial implementation of LTCI in Japan, numerous women's advocacy groups opposed the inclusion of cash benefits in the program. In contrast, South Korea primarily adheres to the principle of providing benefits in kind, but it has introduced special

cash benefits to partially acknowledge cash disbursements. Additionally, the two countries exhibit disparities in terms of individual co-payments. Both South Korea and Japan implement co-payment systems for benefit utilization, ranging from 10% to 30%, as a preventive measure against excessive co-payments through the application of a high-cost medical service system. In the context of South Korea, for example, a co-payment of 20% applies to facility-based care benefits, while a co-payment of 15% applies to home-based care benefits.

3. Delivery

The third dimension under consideration pertains to the long-term care service delivery system. In terms of the governing and operational entities, South Korea is characterized by the predominant presence of the National Health Insurance Corporation (NHIC) as the central administrative body, operating within the framework of a single-insurer system. Conversely, Japan operates under a multi-insurer system, where multiple entities are involved in the administration of LTCI. Concerning the service utilization process, both countries exhibit a notable degree of similarity. They establish internal agencies tasked with the evaluation and classification of care needs, with subsequent service provision contingent upon contractual arrangements with service providers following the assessment process.

Turning to the workforce, both South Korea and Japan employ a national qualification system for the training and certification of care workers, referred to as care protectors in Japan and their equivalents in South Korea. Challenges associated with these care protector systems in both countries are deemed analogous. For instance, despite a growing demand for care protectors, concerns persist regarding their compensation and working conditions, which are often perceived as inadequate, thereby posing impediments to the provision of high-quality care services. Consequently, both South Korea and Japan have been diligently pursuing various policy initiatives aimed at enhancing the conditions and remuneration for care protectors as part of their broader efforts to bolster the long-term care sector.

Shifting this study focus to the examination of the prevalence of home-based service facilities and institutional establishments. Japan's landscape reveals a substantial proliferation of home-based service facilities after the introduction of the extant system. In contrast, institutional entities have increased from 10,992 in the year 2000 to 13,731 in 2021, manifesting a noteworthy 24.9% escalation. Equally discernible is the upsurge in home-based facilities, which has burgeoned from 59,482 in 2000 to 208,634 in 2021, signifying a surge exceeding 2.5-fold. Additionally, the sphere of facilities devoted to preventative care services in domestic settings, inaugurated in 2006, initially surged to approximately 158,128 by 2017. However, by the year 2020, this number had receded by approximately half, evincing a persistent descending trajectory.

In contrast, the trajectory in South Korea

unveils a distinct pattern of institutional expansion, surging by more than twofold, ascending from 2,629 in 2009 to 6,150 in the fiscal year 2022. The domain of home-based services equally exhibits a substantial augmentation, ascending from 11,931 in 2009 to 21,334 in the fiscal year 2022, denoting a substantial increment of approximately 78.8%.

Both countries transitioned toward a shared trajectory characterized by the diminishing significance of facility-based services and the concomitant expansion of in-home care provisions. This strategic shift is underpinned by considerations of efficiency and resource optimization. By curbing the prominence of facility-based care and augmenting in-home care options, both nations sought to enhance the overall effectiveness of their long-term care systems. Furthermore, Japan proactively reinforced its preventive care capabilities, striving to strike a balance in the distribution of benefits between in-home and facility-based care.

4. Finance

The final aspect of consideration pertains to the financial dimension. Both South Korea and Japan administer their respective LTCI programs within the framework of a social insurance model. However, they significantly diverge in terms of their funding mechanisms, with a predominant reliance on taxation. It is pertinent to highlight that Japan has acknowledged the inevitability of raising insurance premiums while concurrently implementing measures to mitigate the repercussions of such increases. These strategic measures encompass the utilization of a financial stabilization fund aimed at alleviating the financial burden on beneficiaries and ensuring the sustained fiscal stability of the LTCI program.

In the realm of social service systems designed for the long-term care of elderly populations, financial sustainability remains a universal challenge faced by nations across the globe. This challenge is similarly pertinent to both Japan and South Korea. An analysis of the composition of financial resources reveals notable distinctions between the two countries. A superficial comparison focusing solely on government contributions and user fees portrays Japan's system as comprising 45% government funding and user fees varying from 10% to 30% (applicable to active income earners). In contrast, South Korea's LTCI system features a relatively diminished government contribution of 20%, juxtaposed with a user fee obligation of 15% to 20%. Furthermore, the mandatory imposition of LTCI premiums on individuals aged 20 and above in South Korea accentuates the financial burden on its populace. This scrutiny underscores that South Korea's LTCI structure places a more substantial financial encumbrance upon its citizenry in comparison to Japan.

In the Japanese context, the introduction of the LTCI system in the year 2000 led to a surge in national expenditures, raising concerns about the system's sustainability. Proposed solutions include shifting user responsibility for sustenance and accommodation expenses from facility support, coupled with an increase in insurance premium rates. However, it is crucial to recognize that such meas-

ures inherently raise the financial burden on the population.

In South Korea, the decision to make the LTCI system accessible to the entire population while initially keeping the insurance premium burden low is a well-known strategy. This approach aimed to minimize dissatisfaction among citizens concerning additional insurance premium contributions during the early phases of system implementation. Nevertheless, as the system continues to evolve, there is potential for sustained growth in demand for long-term care services. Consequently, it is imperative to formulate medium to long-term financial plans that consider the population's capacity to bear the financial burden and the level of economic development.

Both Japan and South Korea have implemented user contributions to bolster the fiscal resilience of their long-term care systems. However, the heightened financial burden tied to certain services disproportionately affects individuals with lower income levels. Additionally, the juxtaposition of premium payments and the increasing demographic of elderly individuals within the low-income stratum, facing challenges in accessing LTCI services, underscores a significant issue.

Within this framework, achieving national consensus on acceptable insurance premium rates becomes paramount. Given the LTCI system's foundation on the principles of national solidarity, obtaining the consent of the population is a fundamental requirement.

Conclusion

Japan and South Korea have embarked on a transformative journey in their healthcare systems for the elderly through the implementation of LTCI schemes. The motivations behind these paradigmatic shifts are multifaceted, showcasing variations in their initiation and progression across the two nations.
However, a shared foundation in the social and cultural contexts of both countries underlies these endeavors, signifying a commonality amidst the diversities inherent in the implementation of these pivotal reforms.

Firstly, both Japan and South Korea face the ongoing challenge of a steadily increasing elderly population attributed to prolonged average life expectancy. This demographic transformation underscores the imperative for the development of a comprehensive and integrated care system, capable of accommodating the diverse needs of the aging individuals.

Secondly, both Japan and South Korea have undergone rapid urbanization and witnessed shifts in household structures. These changes have disrupted the traditional family-centric caregiving model, emphasizing the need for alternative care arrangements to meet the demands of modern society.

Furthermore, the transformation is influenced by evolving perceptions of familial responsibility. Traditional Confucian values, such as filial piety and familial care, are undergoing re-evaluation as societies modernize, shaping attitudes towards the provision of eldercare.

A notable shift in the caregiving landscape has occurred due to the increased participation of women in the labour market. With familial caregiving resources diminishing owing to occupational commitments, the importance of structured and systematic long-term care services has experienced significant rise.

The LTCI programs in both South Korea and Japan were instituted with the dual objectives of ensuring a stable elderly life and redistributing the caregiving responsibilities, traditionally shouldered by families to be shared by society. To achieve these goals, both nations adopted a similar social insurance policy model, resulting in numerous commonalities across the overall policy framework. However, a closer examination of the comparative analysis reveals not only similarities but also differences in the form and level of specific program components. This observation emphasizes the notion that even policies with identical objectives and structural forms can exhibit variations over time based on the specific societal contexts in which they are implemented.

Based on the findings of this research, the implications for the prospective trajectory of community care in Japan and South Korea are as follows.

The primary consideration involves the targeted beneficiaries, with South Korea adhering to a singular insurer paradigm administered by the National Health Insurance Corporation, while Japan adopts a decentralized prefectural government-centric insurance model. Consequently, Japan emerges as a more propitious milieu for the execution of community care initiatives, given the localized genesis, provisioning, and evaluation of pertinent services within the resident geography. Conversely, the monolithic insurer structure in South Korea complicates the discernment of local exigencies, potentially impeding the tailored provisioning of services consonant with regional idiosyncrasies. Therefore, the prevailing conditions suggest that Japan, in comparison to South Korea, provides a more congenial environment for the implementation of community care initiatives.

The second dimension under examination concerns the modalities of benefits, wherein it is arguable that both Japan and South Korea manifest a congenial environment in the realm of infrastructure for the practical realization of community care. The LTCI systems in both nations are fundamentally configured with a foundational emphasis on institutionalized care services and community-based care alternatives. In the context of institutionalized care services, owing to their resource-intensive nature and the imperative of accommodating the projected sustained growth in the elderly population, prudent consideration must be given to the system's overarching sustainability. Consequently, it is tenable to assert that the configuration of the system has shifted towards a pronounced orientation favoring community-based care services as a corresponding strategy. Substantively, it is evident that there has been a substantial augmentation in the quantitative presence of establishments dedicated to the delivery of community-based care services in both jurisdictions. In the comparative analysis, jux-

taposed with the state of affairs in Japan at the juncture of the system's inception in the year 2000, the number of such establishments has escalated by more than 2.5-fold, while in the South Korean context, relative to the system's implementation in 2009, it has nearly doubled. The proliferation of these community-based care facilities for service provision underscores a reasonably conducive infrastructural milieu for the instantiation of community care paradigms. Nevertheless, it is imperative to underscore that notwithstanding the uptick in the quantity of these facilities, an enduring imperative exists to rigorously scrutinize both the quantitative and qualitative dimensions of service delivery.

The third facet under consideration pertains to the aspect of service delivery, where the presence of care managers in Japan confers a distinct advantage in the facilitation of community care initiatives. Notably, both Japan and South Korea have experienced an augmentation in their workforce dedicated to elderly care. However, a salient disparity between the two countries lies in the presence or absence of care managers. In the Japanese context, care managers assume the pivotal role of formulating and administering personalized care plans for elderly individuals. Conversely, South Korea's paradigm lacks the discrete vocations of long-term care support specialists or care welfare workers, thereby delegating such responsibilities to social workers or home helpers. Consequently, within the strict semantic confines, South Korea's specialized workforce within the domain of elderly care is encapsulated primarily by the category of home helpers. Notwithstanding the direct service provision role that home helpers undertake, the tasks involving the development, refinement, and oversight of comprehensive care plans for individuals are entrusted to personnel employed by the National Health Insurance Corporation. This arrangement engenders limitations, particularly in adapting services to align with the evolving and individualized exigencies of care recipients, particularly in instances where dynamic shifts in health status necessitate frequent recalibration of the care regimen.

The following pertains to financial aspects, where both Japan and South Korea implement the LTCI system through a combination of government budgets, insurance premiums, and user out-of-pocket payments. However, there is a disparity in the distribution of these components, with Japan relying more heavily on government budgets compared to South Korea. While this results in lower individual burdens in South Korea, it places a greater strain on the fiscal sustainability of the government.

Moreover, both Japan and South Korea primarily target individuals aged 65 and above or those aged 64 with specific geriatric conditions. Nevertheless, the pool of eligible individuals in South Korea encompasses a broader demographic, extending to health insurance subscribers across various age groups. Conversely, Japan distinguishes the first insured party as those aged 65 and above and designates the second insured party as individuals aged 40 to below 65, subscribed to medical insurance. This distinction bears potential rami-

fications for the sustained financial viability of LTCI, raising concerns about future fiscal needs. In anticipation of these impending financial requirements, Japan has strategically augmented individual out-of-pocket payments, transitioning from 10% to the current 30%. This strategic manoeuvre aligns with the overarching trend of augmenting individual financial responsibility. Furthermore, such adjustments might potentially propagate an escalation in insurance premium trajectories. Noteworthy is the fact that Japan has witnessed a twofold increase in premiums from 2000 to 2023, while South Korea has undergone a similar twofold increment from 2009 to 2022. It is particularly salient that the rate of premium escalation in South Korea appears to surpass that observed in Japan.

Both Japan and South Korea have already instituted LTCI systems that pivot on the foundational principle of home-based care. However, it is imperative to undertake an exploration that transcends mere quantitative expansion and delves into the qualitative dimensions of bolstering home-based care provisions. Numerous nations, including Japan and Germany, are currently evincing a conspicuous trend characterized by the augmentation of home-based care as an integral facet of their long-term care service offerings. This paradigm shift is predicated upon the cogent rationale that elderly individuals derive superior care outcomes when they receive assistance within their familiar domiciliary surroundings, often in concert with their familial support networks, in contradistinction to institutional settings that may be entirely unfamiliar. To effectuate this ethos, both Japan and Germany have adopted strategies encompassing the elevation of home-based care subsidies and the fortification of familial caregiver support mechanisms.

In the context of South Korea, the foundational principle likewise gravitates toward the primacy of home-based care. Nonetheless, critical evaluations have cast aspersions upon the extant system, asserting that it offers a rather circumscribed spectrum of services with benefit levels that fall short of adequacy. This translates into beneficiaries receiving services that are quantitatively insufficient for addressing their requisite daily living assistance. Moreover, the absence of care managers underscores the imperative to establish a framework capable of proffering services that are meticulously tailored to the exigencies of each individual's unique circumstances. South Korea, in response to these exigencies, should contemplate a repertoire of concrete, pragmatic, and intricately detailed alternatives aimed at the substantive enhancement of home-based care.

Notes

(1) Gilbert, N. & Specht, in their seminal works, present four essential criteria for the analysis of social welfare policies, encompassing the examination of benefit recipients, benefit forms, service providers, and funding sources. The adoption of these analytical criteria holds paramount significance as it facilitates a comprehensive and systematic evaluation of welfare policies, thereby shedding light on the underlying role and function of social welfare policy (Gilbert, N. & Specht, H. 1986). Moreover, their contributions include defining the

concept of social safety nets and delineating the classification of social welfare from residual and institutional perspectives, thereby offering a nuanced explanation of the multifaceted functions of social welfare (Gilbert, N. & Specht, H. 1974).

(2) The distinct assistance offered by local government authorities for individuals classified as those in need of long-term care and individuals necessitating care support) entails initiatives focused on mitigating the deterioration of care conditions and proactively preventing the onset of such conditions.

(3) In a detailed examination, three primary components emerge. Firstly, the formulation of care plans for care recipients necessitates continuous management and periodic reassessment. Secondly, it involves the coordination of interactions with service providers, alongside the dissemination of information and the provision of caregiving consultations to both care recipients and their familial support networks. Lastly, an essential facet encompasses the conduct of home visits, commissioned by local municipalities, aimed at scrutinizing the daily living activities of individuals applying for care certification.

(4) South Korea, Germany, and Japan have each opted for a social insurance system, wherein both Germany and South Korea exhibit congruence in contributors between their LTCI and health insurance systems.

(5) The Long-term Care Ccommittee, a subsidiary body within the purview of the Ministry of Health and Welfare, has been established with the primary mandate of convening deliberations and policy formulation concerning the following core facets of LTCI: 1) LTCI premium rates, 2) criteria governing the disbursement of non-special exception care expenses for family caregivers and in-hospital care costs, and 3) cost assessments associated with home-based and facility-based benefit provisions. This committee comprises no fewer than 16 and no more than 22 members, inclusive of a chairman and a vice chairman. Notably, committee members are required to represent diverse organizations and associations with affiliations pertinent to LTCI for elderly individuals, as delineated by the Ministry of Health and Welfare.

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