Asian Journal of

HUMAN SERVICES

Printed 2014.0430 ISSN2186-3350
Published by Asian Society of Human Services

April 2014
VOL. 6

Asian Society of Human Services

Human Services

Asian Journal of Human Services , VOL.6 1-12

ORIGINAL ARTICLE

Comparing the Long-Term Care Insurance Programs of Korea and Japan

: Focusing on Provisions of Care

Sunwoo LEE[1)] Jin KIM[2)]

1) Department of Social Welfare, Inje University
2) Choonhae College of Health Science

ABSTRACT

The Long-term Care Insurance programs Korea were implemented in July 2008 and Japan in April 2000. Though the Korean LTCI has been influenced by the Japanese LTCI, they have dissimilar as well as similar features. The most noticeable difference between the Korean LTCI and the Japanese LTCI is that the former does not have care managers who can perform case management for care users unlike the latter. The Japanese LTCI care managers, however, are hired by care providers. Therefore, care managers may not work for care users' best interests when the interests of care providers conflict with the interests of care users. Poor working conditions such as low benefits and wages, job instability, and heavy workload have led to quality problems in both programs. Thus, measures to improve working conditions of care workers need to be implemented.

＜Key-words＞
Long-term care insurance, Korea, japan, comparison, case management, care workers

sunwlee@inje.ac.kr（Sunwoo LEE）

Asian J Human Services, 2014, 6:1-12.

Received
January 15,2014

Accepted
February 26,2014

Published
April 30,2014

Ⅰ. Introduction

Korea implemented the Long-term Care Insurance (LTCI) for the Elderly in July 2008 women, who used to be family carers, have participated in the formal labor market in large number. Approximately 11.0% in 2010 (expected to be 15.7% in 2020) of the Korean population was aged 65 years and over (OECD average 15%). For six years, the LTCI of Korea has expanded rapidly in terms of the number of beneficiaries and the expenditures.

Japan implemented its Long-term Care Insurance in April 2000 as the proportion of its

aged population became 14.5% in 1995 and its needs for care increased rapidly. The care needs for the elderly became too enormous to be solved by their families alone. The Japanese LTCI has had three reforms since its launching through the every three year insurance plans.

The Korean LTCI is said to be influenced by the Japanese LTCI. Many Korean studies (H. K. Lim, 2008; Um & Park, 2005) introduced the Japanese LTCI before the contents of the Korean LTCI were finalized. After the Korean LTCI launched, several Korean studies (Y. H. Choi, 2011; Jang & Kim, 2009; Park & Kang, 2013) compared between Korean LTCI and Japanese LTCI, but not enough when considering the Japanese LTCI's influences on the Korean LTCI. In addition, most of the comparative studies described Japanese LTC as an exemplary case, and suggested how to improve the Korean LTCI, not paying much attention to the problems that the Japanese LTCI has.

This study tries to compare the Korean LTCI with the Japanese LTCI in the aspects of beneficiaries, type of benefits, finance and provision of care, focusing on care providers and care workers.

Ⅱ. Launching and Reforming the Long-Term Care Insurance Programs of Korea and Japan

Long-term care is "the care for people needing support in many facets of living over a prolonged period of time. Typically, this refers to help with so-called activities of daily living (ADL), such as bathing, dressing, and getting in and out of bed, which are often performed by family, friends and lower-skilled caregivers or nurse"(OECD, 2011: 39).

Korea installed a new LTCI system based on a national compulsory insurance in 2008. Its financing system is very similar to the National Health Insurance system in Korea, which has "consequences for access (defining eligibility), benefits (what is covered, what not), payments for (what do citizens pay under what circumstances) and has workforce repercussions" (OECD, 2011: 56) as opposed to an LTC system tax-based.

The new Korean LTCI based on an insurance system changed the shape of care services for the elderly fundamentally. Care services in Korea used to be delivered by non-profit agencies which were financed mostly by government grants before the introduction of the LTCI. The main recipients for the agencies' care services used to be low income users. As long as care services were delivered, the grants were not influenced by the agencies' efficiency and effectiveness in providing care services.

After the LTCI has launched, the Korean government chose an electronic voucher system for the LTCI under which the National Health Insurance Service (NHIS) issues LTC vouchers to care service users with the LTCI certification. Then, the users may choose any care providers whom they like and make contracts with. The NHIS pays back the costs to the care providers after they provide care services with the users. Therefore, care service providers need to secure enough care users for their stable operation because

more care users means more profits.

The Ministry of Health and Welfare of Korea allowed various organizations to be care providers in the LTCI, expecting that the organizations would compete against each other to provide better services with users. As a result, many agencies, individuals or corporations, have become registered as care providers. For-profit agencies have also been allowed to participate as care providers for the elderly under the LTCI terms.

Japan launched the LTCI in 2000, 8 years before Korea. After the launch, the 1st reform of the Japanese LTCI came in 2005. The 2005 reform emphasized preventive care (such as support services in a community (preventive benefits), prevention services in a community, and comprehensive support services). It also included reform of facility benefits, introduced community-oriented services, and made care service information available.

The 2nd reform of the LTCI came in 2008 because of the nation-wide fraudulent claims and false designation reports by the COMSN, Inc., which was the largest LTCI agency in 2006. The 2008 reform introduced a system to audit the LTCI agencies at their places as a measure to prevent fraudulent cases and to make care providers to follow the LTCI rules. The 3rd reform in 2011 emphasized linking between medical services and care services, recruitment of care workers and improvement of care quality, repairing houses for the elderly, promoting measures for dementia, and alleviating increase in insurance contributions (Ministry of Health, Labour and Welfare, 2013a).

Ⅲ. Comparison of the Long-Term Care Insurance Systems: Korea and Japan

1. Who are beneficiaries?

In Korea, people aged 65 years or over who need care/support or people aged 45~64 years who have geriatric diseases such as dementia and cerebrovascular diseases are eligible for the LTC services. People who want to use care services apply for the LTC at the National Health Insurance Service (NHIS) regional offices. Then, agents from the NHIS visit the applicants' home to investigate their physical and psychological functioning levels and their needs for the LTC services. The investigation for LTCI certification is performed utilizing the Long-Term Care Certification Questionnaire. The questionnaire includes 90 items in 12 sections such as physical and cognitive conditions, behavioral changes, nursing, rehabilitation, needs for care services, environments, etc.

The Category Decision Committee, consisted of doctors, nurses, and social workers, makes decisions on LTCI categories 1 to 3, or no category with consideration of the investigation results and doctors' opinions.

If LTCI applicants are certified as categories 1 or 2, they may use either home care or institutional care. If they are certified as category 3, they may use only home care. Agents of the NHIS prepare the standard LTC use plans for those with the LTCI certifications.

With the LTCI certifications, service users make contracts with the LTCI agencies (care service providers) for the services they need.

The number of people with LTCI certifications in Korea sky-rocked from 214,480 on Dec. 2008 to 315,994 on Dec. 2010, by 47.3% for the first two years after the LTCI launch. But, the increase of people with LTCI certifications slowed down for the next two years, only by 3.7%.

<Table 1> Change of Insured individuals of the Long-Term Care Insurance in Korea

	Dec. 2008	Dec. 2009	Dec. 2010	Dec. 2011	Jun. 2012
Number of people aged 65 and over	5,086,195	5,286,383	5,448,984	5,644,758	5,801,127
Number of LTCI applicants	355,526	522,293	622,346	617,081	627,800
Number of people with LTCI certification (Ratio to applicants)	214,480 (60.3%)	286,907 (54.9%)	315,994 (50.8%)	324,412 (52.3%)	327,766 (52.2%)
Ratio of people with LTCI certification to people aged 65 and over	4.2%	5.4%	5.8%	5.7%	5.7%

Source: National Health Insurance Corporation; D. Sunwoo (2013).

By support or care levels, those certified as the support 1 were 690,000, those certified as the support 2 were 710,000, those certified as on the care level 1 were 970,000, those certified as on the care level 2 were 950,000, those certified as on the care level 3 were 720,000, those certified as on the care level 4 were 660,000, and those certified as on the care level 5 were 610,000 in 2012. Thus, those with low levels of certification (support 1 ~ care level 2) were comprised of 62.4%, while those with high levels of certification were 37.6%.

Those certified as on the support or on the care may use services according to their care (prevention) plans and their levels of certification. Care plans are usually prepared by care managers who are mainly hired by the LTC agencies (care providers). Care managers write out care plans based on service users' needs and their situations and make contracts for provision of care with them.

2. Types of LTCI Benefits

The Korean LTCI provides mainly in-kind care services while it provides cash benefits only for those living in remote areas where care service providers are not available. The LTCI care benefits are consisted of home care and institutional care. Home care benefits include home-visit care, home-visit bathing, home-visit nursing, day/night care, short-term respite care and welfare equipment such as wheelchairs and orthopedic

mattresses.

The proportion of home care users was 59.7% of all the LTC recipients, while institutional care users are 40.3% in 2008. The proportion of home care users climbed up to 72.7% in 2009, but it came down to 62.5% in 2012. In terms of the amount, the proportions of the expenditures on home care were above 50% (65.0% in 2009 and 55.0% in 2010), but the proportion of the expenditure was 48.2% in 2012 even though the proportion of users was 62.5%, which reflected the fact that the cost per unit for institutional care is more expensive than the cost per unit for home care.

<Table 2> Change of the Long-Term Care Users by Types of Benefits in Korea

Units: Persons, Million Won, %

		Dec. 2008	Dec. 2009	Dec. 2010	Dec. 2011	Jul. 2012
Number	Subtotal	132,227	219,244	264,335	270,883	274,977
	Institutional Care	53,333 (40.3)	59,876 (27.3)	86,759 (32.8)	97,381 (35.9)	103,200 (37.5)
	Home Care	78,894 (59.7)	159,368 (72.7)	177,576 (67.2)	173,502 (64.1)	171,777 (62.5)
Amount	Subtotal	129,916	224,462	256,030	251,123	264,540
	Institutional Care	68,956 (53.1)	78,611 (35.0)	115,274 (45.0)	127,142 (50.6)	137,124 (51.8)
	Home Care	60,960 (46.9)	145,851 (65.0)	140,756 (55.0)	123,981 (49.4)	127,416 (48.2)

Source: E. J. Han et al. (2012).

In Korea, home visit care took the largest share of the home care benefits. 85.5% of the home care users used home visit care in 2012, while only 2.4% of them used home visit nursing (Han et al., 2012).

In Korea, there have been criticisms on the costs of home visit care and home visit nursing. Currently, the costs for home visit services reflect differences between day and night, and between weekday and weekend, but not differences in users' conditions (D. Sunwoo et al., 2008). Though care users may be in the same LTCI category, they may need different levels of services depending on their conditions. In general, users with dementia or with problematic behaviors need more services. Thus, care providers may try to avoid users who need high level of services, and to accept users who need low level of services.

The Japanese LTC services include care benefits and preventive benefits. First, care benefits include home care services (home help service, home visit bathing care, home visit nursing, home visit rehabilitative services, day service, short-stay daily-life service),

facility services (welfare facilities for the elderly requiring care, health service facilities for the elderly requiring care), and community-oriented services (regular visits/on-call visits home help service, home help service at night, daily-life group care for the elderly with dementia). Second, preventive benefits are for those who need support. Preventive benefits include facility services, but with prevention services and community-oriented prevention services.

As of April 2012, 14.2% of those aged 65 years or over used the LTC in Japan. Among them, 73.7% used home care, 19.3% used institutional care, and 7.0% used community-oriented care services. Only 80.7% of those certified as on the support or on the care actually used the LTC services (Ministry of Health, Labour and Welfare, 2012a, 2012b). The expenditures on prevention services in community have been increasing, and 70.5% of its beneficiaries are on the low level of certification (support 1 ~ care level 2).

3. Finance

The main financial source for the Korean LTCI is insurance contributions which are 6.55% of the premium for the National Health Insurance, and the central government subsidizes 20% of anticipated insurance contribution receipts. The Korean LTCI also requires a 15% user co-payment for home care and a 20% cost sharing on institutional care, which can limit people's access to LTC services.

In Japan LTC service users pay 10% user co-payment. The Japanese government subsidizes 45% of the total budget for the LTCI. Insurance premiums for category 1 insured people are comprised 15%, and those for category 2 insured people are comprised 30%.

4. Provision of Care

1) Agencies in Long-Term Care Insurance

In Korea, agencies in the LTCI are certified by primary local governments (called Si·Gun·Gu) if they are able to satisfy the national minimum standards for personnel and facilities. The Korean central government has been criticized to be only concerned with securing the infrastructure for the LTCI, but not with the effects of marketizing social services (J. E. Seok, 2010).

As a result, care providers have become excessive in the Korean LTCI, which has led to other serious problems such as low quality services and bad working conditions for care workers (H. S. Jegal, 2009; J. E. Seok, 2010; D. Sunwoo, 2013). Agencies for community-based care were increased by 93.9%, and agencies for institutional care were increased by 143.7% for less than 4 years. Especially, small agencies for institutional care accommodating less than 10 care users were increased by 323.7%.

<Table 3> Number of LTCI agencies in Korea

		Dec. 2008	Feb. 2012	Change in %
Community-based Care	Subtotal	10,033 (100.0)	19,457 (100.0)	93.9
	Home-visit care	4,271 (42.6)	8,655 (44.5)	102.7
	Others	5,762 (57.4)	10,802 (55.5)	87.5
Institutional Care	Subtotal	1,700 (100.0)	4,142 (100.0)	143.7
	Less than 10	406 (23.9)	1,720 (41.5)	323.7
	10~Less than 50	692 (40.7)	1,568 (37.9)	126.6
	50 or more	602 (35.4)	854 (20.6)	41.9

Source: National Health Insurance Corporation; D. Sunwoo (2013).

The average care users per LTC provider were only 21.3 persons for institutional care, and only 16 persons for home care. Fierce competition among care providers has made them put more efforts on recruiting more LTC users, which has resulted in use of unnecessary care services and increase in the LTCI expenditures. Some LTCI agents in the effort of recruiting more care users, would exempt or reduce users' co-payment, and even bribe them in order to allure users into them while they would overcharge the NHIS. They would report service hours more than they provided or even report services which they did not provide at all. Moreover, they would not hire care workers necessary for providing care or would pay them very low wages (Jegal, 2009; Lee & Kim, 2013; J. E. Seok, 2010).

Utilizing market in proving care services had another disadvantage. Care services were not provided adequately where profits are expected to be low such as farming and fishing villages (H. S. Jegal, 2009; D. Sunwoo, 2013). Thus, provision of care services is unequally distributed among regions.

Thus, marketizing long-term care has not led to efficient provision or to better quality of care services. According to J. E. Seok (2010), it has created more social cost in that the amount of the LTCI benefits has increased more in for-profit care providers and in large cities where competitions among care providers are fiercer.

In Japan, care providers are designated by governors of Prefectures if they satisfy requirements for personnel and facilities. Private for-profit corporations, medical corporations, non-profit organizations as well as municipal offices or social welfare corporations may become care providers for the LTCI. For-profit corporations took the largest share in home care services: 58.6% of home help service, 46.4% of day service, 67.5% of daily-life care service in specified facilities, and 91.6% of rental for welfare equipment. On the contrary, social welfare corporations and medical corporations accounted for most of institutional care: 92.3% of welfare facilities for the elderly requiring care run by social welfare corporations, 74.3% of health service facilities for the elder requiring care and 81.9% of sanatorium type medical care facilities for the elderly requiring care run by medical corporations (Ministry of Health, Labour, and Welfare, 2012). The marketization of care providers in home care has been accelerated with

consistent policy to strengthen home care services by the Japanese government.

2) Long-Term Care workers and their working conditions

As the LTCI launched in 2008, the Korean government was so concerned with the provision of care services. Therefore, the government adopted a policy to increase care workers as well as care providers. Institutions to educate and train care workers were easily set up without any difficult requirements to fulfill. Moreover, certificates for care workers were easy to obtain. Jegal (2009) criticized that even high school students and the elderly who could not read and write Korean characters obtained care worker certificates. As a result, the number of care workers with qualifications in Korea has been increased incredibly. In 2012, people with care worker certificates are estimated at 109 million.

Only 20% of people with care worker certificates, however, are working as care workers, mainly because wages and working conditions are much less than good (D. Sunwoo, 2013). Thus, LTCI agencies have difficulty in hiring care workers. The bad working conditions also affected the composition of care workers. 73.1% of all care workers are female in the 40s or 50s, and 19.8% are people aged 60 years and over (D. Sunwoo, 2013). Care services in Japan are provided by home helpers, care workers, social workers and nurses, but home helpers are the main direct care workers both in home care and institutional care. People had to complete a 130 hour study and training course for home helpers. The course was shut down. Since April 2013, people have to complete a study and training course for beginning care workers to work at home helper sector, in home care or in institutional care. The course is consisted of 130 hours of theory and practice, and a one-hour written exam at the end (http://www.fukushihoken.metro.tokyo.jp/kiban /koza/syoninsyakensyu/kankeikitei.html).

In general, working conditions for care workers are poor across OECD countries. “Care work is demanding and burdensome, leading often to early retirement due to stress and burnout” (OECD, 2011: 169).

Wages for care workers are low, too. Korea is no exception. Wages for care workers in the Korean LTC are about 1,300,000 Won (USD 1,200) monthly in institutional settings, 7,000 Won (USD 6.7) per hour in home care. Moreover, care workers in home care usually do not have enough care users due to too many LTC agencies in the market. Thus, their average monthly wage is lower than that in institutional settings (Lee and Kim, 2013).

In Korea, care workers’ status at work is unstable. 66.7% of care workers in home care are temporary workers, while 27.9% of them in institutional care are temporary workers. 48.5% of them have duties unrelated to care. 12.8% of them have experienced sexual harassment. There are no systems to give supervision or collegial support to care workers (J. E. Seok, 2010).

Unlike the Korean LTCI, the Japanese LTCI has two different levels of care workers. Care managers are considered as professionals with better working conditions. Their

wages were JPY 260,712, which was lower than other occupations. They were 46.1 years old in average, and working 6.1 years in average. 73.4% of them were permanent workers (Care Labor Security Center, 2009). Nonetheless, care managers who leave their jobs due to heavy job-loads are not uncommon at small LTCI agencies (Kamiya, Shiraki & Takasuna, 2008).

On the contrary, most home helpers in Japan work as temporary workers. More than 80% of home helpers work only when they have clients (Hotta, 2012). They usually renew their registration every 6 months or one year. Care workers have rapidly increased since the launch of the LTCI, but securing, retaining, and educating care workers, which is fundamental for providing high quality of care services, is still problematic and considered as an urgent issue. The shortage of care workers has become chronic because the job status of care workers is still insecure and their wages are low.

3) Quality of Care Services

The quality of care services is heavily influenced by educational programs for LTC workers as well as national regulations set minimum requirements to qualify as an LTC worker. Many countries — especially for lower-level workers — have educational programs that combine some theory with practice training (OECD, 2011).

In Korea care workers must complete 240 hours training course (theory 80 hours, skills 80 hours, practice 80 hours) as a minimum requirement, which is not enough for quality care. The Korean training scheme for care workers has been criticized to be problematic. The number of educational institutions for care workers was 1,407 in 2010, which meant 6 institutions for each primary local government in average. Too many educational institutions for care workers have been established because the Korean government chose a notification scheme for the educational institutions, which anyone or any corporation may establish an institution if they meet the minimum requirements. Thus, the educational institutions have to compete against each other to secure trainees, which leads to unreliable education and training and to low quality of education.

The educational scheme for care workers converted to a designation scheme, which primary local governments designate as educational institutions. Moreover, care workers may obtain care worker certificates after they complete the educational course and pass the national qualification examination since 2010 (J. E. Seok, 2010).

Japan has several training levels for LTC workers. Training is available to enable qualification as a care worker or as home helper. Case management in the Japanese LTCI, which is provided by care managers or care workers, is another important scheme to improve and maintain care quality.

Japan also introduced community comprehensive support centers. The centers provide services which respond to the needs of or the change of conditions of the elderly on the care. They help the elderly on the care stay in the community where they have lived. Their services include overall counseling, care prevention management, comprehensive

and continuing management, preparation of care preventive service plans, and care management (Jang & Kim, 2009).

As another quality control scheme for care services, Japan introduced a renewal system of LTCI agencies to eliminate fraudulent and/or low quality care providers. This system requires LTCI agencies to renew their LTCI agency designation every 6 years (Jang and Kim, 2009).

Ⅳ. Conclusions

The marketization of care services in Korea was expected to bring in more efficient and better services. Unlike the expectation, the marketization without necessary regulations has brought about regionally unequal distribution of care providers, low quality services, and large number of low wage workers. Japan was not different from Korea in that working conditions were bad for care workers.

One of the most noticeable differences between the Korean LTCI and the Japanese LTCI is that the former does not have care managers who can perform case management for care users unlike the latter. In Japan, care managers prepare care plans and perform case management. They communicate and coordinate with municipal offices and care providers for care users. In Korea, agents from the NHIS only prepare care plans, and no one performs case management for care users.

The Japanese LTCI has the case management function, but it has its own problems in that care managers are hired by care providers. Therefore, care managers have to work for their employers as well as for care users. When the interests of care providers conflict with the interests of care users, care managers may not always work for care users' best interests. Thus, if the Korean LTCI introduces case management, case managers should be hired by local governments.

For-profit providers are needed for the provision of long-term care services in Korea as well as in Japan. Nonetheless, it should be remembered that LTC services are social services which public fund are expended on. Thus, the market for LTC needs to be regulated properly. Even other markets without any public fund are often regulated to protect consumers. Governments should intervene with the market for LTC services to choose adequate care providers and to control quality of care services.

Recruiting and retaining qualified care workers is essential for providing quality care services. Low benefits and wages, job instability, and heavy workload may "lead to recruitment problems, high turnover, workers leaving the sector and workers limiting the number of years spent working in the sector" (OECE, 2011).

Thus, measures to improve working conditions of care workers need to be implemented. Most of all, the governments need to set proper costs for care services considering service difficulties, differences in care users' conditions, and regional differences.

Reference

1) Care Labor Security Center(2009) Regarding survey of care labor conditions.
2) Eunjung Han, Jungmyeon Lee, Jungwan Cho, & Dohoon Kim(2012) A Reform Plan for the Support System to Use the Long-Term Care Services, *Health Insurance Policy Institute*.
3) Hotta Satoko(2012) Various problems to secure care workers – Based on the Dutch Experiences-, *Quarterly Social Security Study*, 47(4), 382-400.
4) Hyekyung Lim(2008) Reform of the long-term care insurance system in Japan: Policy suggestions, *Korean Social Security Studies*, 24(1), 233-258.
5) Jaeeun Seok(2010) The Improvement of Long-Term Care Insurance from the perspective of service providers, *Health and Welfare Policy Forum* Oct, 34-44.
6) Kamiya Yoko, Shiraki Yuuko, & Takasuna Hiroko(2008) A Round-table talk: What we aim for, *Care manager,* 10(4), 28-31.
7) Keunhong Lee, & Hyundeok Kim(2013) A Study on the Problems of and an Improvement Plan for Long-Term Care Insurance for the Past Six Years, *Journal of Social Science Research*, 283-298.
8) Kiwook UM, Ina Park(2005) Evaluation of the Four Years Execution of the Long-term Care Insurance System in Japan and its Implications, *Social Welfare Policy,* 21, 295-318.
9) Ministry of Health, Labour and Welfare(2012a) A Report on the Conditions of Long-term Care in 2011.
10) Ministry of Health(2011) Labour and Welfare (2012b) Survey of Long-term Care Benefit Expenditure Summary.
11) Ministry of Health, Labour and Welfare(2013a) About the 2011 Amendment of the Long-Term Care Act.
12) Ministry of Health, Labour and Welfare(2013b) Situations of the Public Long-Term Care Insurance System and Its Role in the Future.
URL:http://www.mhlw.go.jp/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/gaiyo/dl/hoken.pdf
13) OECD(2011) Help Wanted? Providing and Paying for Long-term Care.
14) Sechul Jang, & Kyung Min Kim(2009) The Comparison of Long Term Care Insurance between Korea and Japan, *Japanese Literature*, 42, 325-345.
15) Sunwoo Duk, Soohyung Lee, Changgyun Sohn, Geunchoon Yoo, Hosung Shin, Young Choi, Hyeji Choi, & Jisun Oh(2008) A study on the Improvement of Long-Term Care System for the Elderly. *Korea Institute for Health and Social Affairs*.
16) Sunwoo Duk(2013) Development Directions for Long Term Care Program in Korea, *Health and Welfare Policy Forum*, Jan, 64-75.

17) Yoonja Park, & Youngsook Kang(2013) A Comparative Study on the Operation of the Senior Long-Term Care Insurance System on Korea and Japan, *Japan Culture Study* 45, 173-192.
18) Younghoon Choi(2011) The Comparison of Long-Term Care Insurance between Korea and Japan and Policy Implications, *Korea Policy Research* 11(2), 351-366.

Asian Journal of Human Services
VOL.6 April 2014

CONTENTS

ORIGINAL ARTICLES

REVIEW ARTICLES

SHORT PAPER

Published by
Asian Society of Human Services
Okinawa, Japan