Facing the Aging Crisis:
A Comparison of Financing Systems for LTC Provision in East Asia

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(Work in progress, please do not circulate)

Introduction

In recent decades, East Asian countries are increasingly facing an ageing crisis (Chomik and Piggott 2015: 200, World Bank 2016) which is expressed through a stark decline in fertility rates and a rapidly growing elderly population (World Bank 2016). This aging crisis is exacerbated by a growing change in family values and familial obligations (Chan et al 2011: 184). Simultaneously, East Asian countries have had to cope with two financial crises since the mid-1990s. After the Asian financial crisis in 1997 resulted in immense losses on regional financial markets and in economic growth (Goldstein 1998: 1-5; White and Goodman 1998: 3), the recent global financial crisis of 2008/2009 once again hit East Asian economies at a time when "Japan, Hong Kong SAR, and Singapore [were] already in "technical" recession and Korea [was] experiencing the biggest quarterly decline in GDP growth since the Asian financial crisis" (IMF 2009).

Although there are differences in the severity of the ageing crisis and financial crises among East Asian countries (Chomik and Piggott 2015: 199), it is nevertheless astonishing how dissimilar these countries' responses to growing demographic challenges in times of economic decline are. Whereas countries such as Singapore and Hong Kong have done rather little to enhance state support for the elderly (Chomik and Piggott 2015: 200), Japan, South Korea and Taiwan have introduced measures to provide universal long-term care (LTC) to their elderly (Kwon 2008: 131; Wang and Tsay 2012: 466). This latter policy change is surprising as these three countries have been regarded as prime examples of the so-called "East Asian welfare state model" (White and Goodman 1998; Kwon 2009) which is based on employing social policies for economic development and the degree of de-commodification is rather low (Lue 2014: 279). In this East Asian "productivist" welfare state model (Holliday 2000; Aspalter 2006), welfare states are commonly characterized by low state expenditure and a reliance on family welfare obligations (Mehta 2013: 191). The fact that the three countries have introduced governmental LTC plans and social insurance schemes despite their "productivist" legacy and continuous financial hardship demonstrates a puzzle.

Basing the analysis on a historical institutionalist framework, this paper explores what kind of financing systems Japan, South Korea and Taiwan have created to mitigate the demographic and financial challenges underlying the provision of long-term care for the elderly. In particular this paper asks: Why have the three

countries opted for this particular financing system of social insurance? And in doing so, to what extent are they moving away from the "productivist" East Asian welfare state model?

Literature Review

Reviewing the scholarly literature on these issues, it becomes clear that the three countries' LTC insurance schemes strongly differs from other East Asian, "productivist" welfare states ((Holliday 2000; Aspalter 2006; Kwon 2009; Mehta 2013). While facing similar future demographic trajectories and financial constraints, Hong Kong and Singapore, for instance, have chosen to continue their minimal LTC provision which is based on means-tested elderly care in community centers and residential homes as well as emphasizing family care responsibilities (Chan 2011; Chin and Phua 2016). Albeit growing state investment in LTC infrastructure, Japan, South Korea and Taiwan had followed a similar approach until the late 1990s. In 1997, Japan was the first to deviate from this model by launching its LTC insurance scheme, which came into effect in 2000 (Campell and Igekari 2000; Shirasawa 2015). South Korea was next to adopt such as a system in 2007, commencing in 2008 (Kim and Choi 2013), followed by Taiwan who has recently adopted a LTC insurance in 2015 (to be implemented by 2018; Wang and Tsay 2012; China Post 2015).

At first glance, these developments appear to be a process of policy learning (Heclo 1974, Sabatier 1987; Rose 1991; Hall 1993) among historically linked nation-states. The successive adoption of such LTC social insurance schemes over the last two decades, and the fact that Japan has historically influenced South Korean and Taiwanese state-building and economic development due to its role as a colonizer and source of development policies (Cheng 1990: 140; Woo-Cumings 1998: 324) point the a potential influence of Japan's LTC policies on the development of LTC insurance schemes in other East Asian countries (see Campell et al. 2009). Yet, as this paper will show, when taking a closer look at the design and the financing systems of the three countries, it becomes apparent that South Korea and Taiwan did not merely emulate the Japanese LTC law.

In fact, there are a number of differences between the systems. Whereas the Japanese LTC financing system, for instance, is based on substantive taxed-based support (45%)[1] (Kwon 2008: 126), the South Korean LTC financing system obtains 80% of its funds from the insured, through individual contributions (60%) and co-payments (20%) (Duk 2012: 54). In contrast, the Taiwanese system foresees a tripartite funding scheme, in which the employer (40%), the employee (30%) and the state (30%) all share the burden of LTC financing (China Post 2015). Not only are they funded differently, but they diverge in terms

[1] The other 55% are derived from social insurance contributions (45%) and co-payments (10%) (Kwon 2008: 126)

of social insurance governance, in coverage, needs assessments, benefits etc. In addition to significant variations in their social insurance scheme, there are substantial differences in domestic demographic, financial and institutional characteristics.

In sum, although they have all followed a productivist logic to social policy, are historically linked and face growing demographic and financial challenges, the three countries also exhibit considerable differences in terms of LTC insurance design, their political system, institutional environment, the role of social movements as well as the severity of financial and/or demographic crisis. While taking international policy learning effect and interconnected historical development trajectories into account, this thesis goes beyond the existing literature by examining how the three LTC financing systems differ and which domestic factors have influenced the decision to adopt a social insurance scheme in these East Asian countries. In the following I will first outline this study's theoretical and methodological framework before successively introducing each case study. I will conclude the paper by comparatively assessing the three cases' LTC systems and drawing preliminary conclusions as to their potential divergence from the productivist model.

Theoretical Framework

How to theoretically conceptualize "care" has been subject of debate. Daly and Lewis (2000) demonstrate that "care" commonly is insufficiently defined. They argue for understanding care as "social care" which refers to "the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out" (Daly and Lewis 2000: 285). As a form of social care, long-term care can be defined as services to individuals who are in need of long-term support and who receive assistance mostly from family members, friends or professional care-givers in so-called activities of daily living (ADL) such as bathing, dressing, and getting in and out of bed (Colombo et al. 2011: 39). Following McCall (2001) LTC thus "refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities" (2001: 3).

Each countries' LTC provision varies according to its mix of informal care, community care or institutional care provision (see McCall 2001: 3-4) as well as according to its financing system and coverage, which emphasizes means-tested programs, social insurance schemes (de Roo et al. 2004), tax-based systems (Kwon 2008: 125), out- of-pocket private spending, or a composition thereof. As de Roo et al. (2004) point out, LTC arrangements in different countries are often compared according to the public/private mix of funding (sources of funding), who administers these funds (governance structure), who is eligible to obtain LTC (eligibility; access procedures), which services are provided (entitlement), in what form (cash or kind

benefits) and by whom (organization of supply) (2004: 281-284). These analytical categories will form the bases of the comparison of the East Asian LTC financing systems.

To understand why these LTC financing systems differ from another, the thesis draws on a historical institutionalist framework (Thelen and Steinmo 1992; Hay and Wincott 1998; Pierson 2004; Streek and Thelen 2005; Fioretos 2011) which focuses on how contemporary institutions or policies change by identifying historical legacies and path-dependent developments, the timing and sequence of policy change as well as the influence of particular veto-players or points on institutional or policy change. Following Thelen and Steinmo (1992), historical institutionalism enquires into how formal institutions shape political conduct over time by influencing actor's interests and the power relations they are embedded in (1992: 2-3). In this approach institutions are considered to be path dependent[2] as historical trajectories constrain the way institutions are created and evolve other time. Historical institutionalism therefore emphasizes the significance of timing and sequence of events such as critical junctures and their impact on political power, strategies, preferences and identities of actors, the institutional environment as well as actors' knowledge thereof (Hay and Windcott 1998: 954-955, Fioretos 2011: 375). Although institutions are considered to create a state of equilibrium of constant reproduction, exogenous shocks to the system or critical junctures may lead to radical change in the institutional environment (Pierson 2004: 44-53; Streek and Thelen 2005: 7).

Whether or not institutions change and to what degree is dependent on the number of veto points and veto players in the political-institutional system which impede or facilitate institutional or policy change (Immergut 1990, 1992; Tsebelis 1995, 2002). As political decision-making is based on a country-specific legislative process, in which the agreement of particular actors is needed for the legislation to pass to the next stage, the way political institutions are shaped and how actors inside them use their veto power is significant for understanding policy change (Immergut and Anderson 2006: 7). For this reason, the governing party (or parties), their policy preference (Tsebelis 1995; 2002), the role of non-state actors (such as trade unions or social movements) (Ebbinghaus 2011; Fleckenstein and Lee 2014) as well as electoral politics (Pierson 1995) all potentially shape how and to what degree policies change. Drawing on historical institutionalist as well as veto-point theory literature, I have selected explanatory factors to analytically examine to what extent the policy outcome (the LTC social insurance scheme in the respective country) can be explained by these factors. The explanatory factors selected are (1) the nature of the

[2] Path-dependence refers to "particular courses of action, [which] once introduced, can be virtually impossible to reverse; and consequently, political development is often punctuated by critical moments or junctures that shape the basic contours of social life (Pierson 2000: 251).

political institutions, in particular whether it's executive regime is parliamentary or presidential as well as the role of second chambers, reference, constitutional courts (Immergut 1992, Immergut and Anderson 2006); (2) the electoral and party system (Bonoli 2000; Persson and Tabellini 2002); (3) electoral politics (Pierson 1995); (4) the institutional infrastructure of health care and pension provision[3] (Pavolini and Ranci 2008); (5) the role of non-state actors (Ebbinghaus 2011, Bonoli and Panier 1997); (6) the influence of policy legacies and timing of events (Pierson 1995, 2004); and finally (7) the role of policy learning (Heclo 1974; Hall 1993).

Finally, an analysis of why and how the three countries have set up their LTC financing systems provides insight into dynamics of welfare state change. Welfare state change is regarded as the result of a plurality of forces such as globalization (Brady et al. 2005), new social risks (Taylor-Gooby 2004; Bonoli 2005) or party competition (Allan and Scruggs 2004; Korpi and Palme 2003). These forces result in, for instance, changes in social spending (Castles 2002; see also Esping-Andersen 1990), welfare institutions and programs (Allan and Scruggs 2004, Castles 2002: 615) and the overall welfare state structure (Pierson 1995: 15). Due to the complexity of welfare states, a growing number of authors argue for conducting studies of particular policy domains (Castles 2002: 614-15, Clausen and Siegel 2007: 6) such as LTC policies. This study therefore examines the introduction of "path-departing" (see Ebbinghaus 2005a) LTC financing systems in East Asia against the backdrop of overall macro-level change in these countries.

Methodological Approach

This study retrace the institutional change underlying the introduction of LTC financing systems within the larger welfare state regimes in Japan, South Korea and Taiwan over the last 20 years (since the Asian financial crisis of 1997) by conducting qualitative comparative case study. I have comparatively examined the macro-level institutional framework and the embedded LTC financing systems in these three countries as only a thorough and detailed small-N analysis would be able to provide answers to how the financing systems differ and why. Employing a most-similar case study design (see Skocpol 1981; Ebbinghaus 2005b), I have chosen three rather similar countries (Japan, South Korea and Taiwan) as case studies since they have all initiated seemingly path-diverging social policy change by introducing a LTC insurance scheme, yet strongly differ in policy outcome. To examine the three cases under research, I firstly use the descriptive categories of social insurance financing systems mentioned above (e.g. private/public financing mix, governance structure etc.) to comparatively illustrate the historical development and characteristics of the

[3] As LTC schemes are often modelled to substitute or complement the health care and pension system (Pavolini and Ranci 2008: 247) and these systems are indicative of the overall institutional logic, they are also taken into account.

three LTC systems. In doing so, I moreover deductively test whether the theory-based explanatory factors outlined above may explain policy outcome (LTC financing schemes) in each country (within-case). In a second step, I compare the three cases in the light of these explanatory factors and discuss the merit of each explanatory factor for explaining the patterns of policy change across the three case studies. Finally, I evaluate the findings against the backdrop of the scientific literature on East Asian welfare state models and welfare state change. The study is based on an analysis of primary documents in English and Mandarin Chinese[4] (laws, policies, ministerial white papers, press releases) and secondary sources such as scholarly studies in Mandarin Chinese (obtained via CrossAsia.org) and English language as well as influential domestic newspapers (e.g. Asahi Shinbun, Taipei Times).

By comparing the different financial LTC financing systems in each country and examining potential domestic reasons for adopting this particular system, I seek to provide a more detailed analysis of the complex processes that underlie welfare state change in East Asia as well as to demonstrate to which degree these systems are moving in the same direction and thus away from their "productivist" legacy. Not only does this study provide a more in depth analysis of how domestic political-institutions as well as state and non-state actors in these three countries have contributed to policy change, it also contributes to the literature by including the recent case of Taiwan's LTC social insurance scheme. Finally, by taking a historical perspective, this study will potentially be able to derive policy implications concerning, for instance, which LTC financing scheme has proven to be more financially sustainable.

The Case of Japan: The Asian Forerunner

Following first policies aimed at providing means-tested elder care in 1963[5] (Ihara 1997: 8; Olivares-Tirado and Tamiya 2014: 17), a rising number of elderly sought care in Japan's health care system since its universalization in 1973 (Shimizutani 2013: 6). This policy change resulted in a ten-fold increase from 1963 to 1993 in the number of elderly Japanese occupying hospital beds for an extended amount of time and massive costs for the health sector (Campbell and Ikegami 2000: 28; Tsutsumi 2014: 4). Since the late 1980s, Japan's growing aging population, changing family constellations and the resulting insufficient care became a publicly discussed political issue (Peng 2005: 82; Tsutsumi 2014: 5). Due to the increasing public and political attention, in the wake of the 1990 election, the conservative Liberal Democratic Party (LDP) made the socialization of elder care[6] a part of their electoral campaign in 1989 (Usui and Palley 1997: 372).

[4] As I am fluent in Mandarin Chinese, I will be able to examine Taiwanese original documents.
[5] For details on the Act on Social Welfare for the Elderly, see Tsutsumi 2014: 3.
[6] Socialization of care refers to the "state assumption of a substantial portion of the responsibility for care of the frail elderly" (Campbell and Ikegami 2003: 21)

As Campbell et al. (2009) remark, it was particularly "Hashimoto Ryûtarô, the Finance Minister, a powerful leader of the Liberal Democratic Party (LDP), and also an ex-Minister of Health and Welfare, [who] committed his governing party to a new policy for the frail elderly" (2009: 66). The LDP started promoting the adoption of a ten-year "Golden Plan" which would create a new means-tested national infrastructure for elder care funded by a new consumption tax which would shift care responsibilities from hospitals and nursing homes to community centres and in-home services (Ihara 1997: 2; Tsutsumi 2014: 5). However, shortly after the enactment of the Golden Plan, Japan's bubble economy collapsed (Peng 2005: 83), resulting in politicians and the media calling for a revision of the Golden Plan and cutting down on welfare state spending (Campbell and Ikegami 2000: 27). In addition, the progressive Democratic Party of Japan (DPJ), the main opposition party, "attacked it as too little, too late and as not really relieving caregivers' burdens" (Campbell and Ikegami 2000: 29). In fact, despite the Golden Plan, surveys in the early 1990s showed that most elderly remained excluded from LTC (Peng 2005: 83-84).

Meanwhile, following the burst of the economic bubble, the Japanese political landscape at the time was undergoing many changes (Peng 2005: 83), as the LDP, for the first time since 1955, had lost the 1993 elections only to return to power in 1994 under a three-party coalition with the Social Democratic Party of Japan (SDPJ) and the New Party Sakigake. Furthermore, in 1994, the Japanese electoral system was reformed, establishing a two-tier mixed system of single member districts and proportional representation which put more weight on urban voters and created the need for parties to advocate broader universal, in contrast to social group oriented, policy reforms (Estévez-Abe and Kim 2016: 12). These reforms thus played a key role in the push for the introduction for a LTCI system as it enhanced party competition and made it imperative to appeal to a broader voter base.

Although a revised "New Golden Plan" was adopted in 1994, the Minister of Health and Welfare at the time, Keigo Ouchi of the Social Democrat Party, established several expert and advisory councils from 1993 to 1995 in order to devise a new long-term solution. Overall, the Social Democrats were more enthusiastic about enacting a social insurance scheme, while many members of the conservative LDP were in favor of supporting traditional family-based care. Yet, when Ryutaro Hashimoto, the LDP Finance Minister who had pushed for the Golden Plan in 1989, became Prime Minister in 1996, he furthermore strongly supported the enactment of a social insurance scheme, paving the way for its adoption in 1997 (Tsutsumi 2014: 6-11). In addition, many non-state actor were actively pushing for a social insurance solution such as representatives of physicians associations, (Campbell and Ikegami 2000: 29-30; Campbell et al. 2009: 71), the Women's Association for a Better Aging Society, the "10,000 Citizens' Committee for Promoting Public-supported Long-term Care" and the Japanese Trade Union Confederation (RENGO) (Tsutsumi 2014: 6).

Therefore, Peng (2005) argues that in addition to the political crisis (the LDP's loss of dominance since 1993) and the public crisis (demographic and family changes), it is particularly the increasing involvement of civil society which led to an expansion of elder care in Japan (2005: 83).

In search for a solution, the Japanese government studied European models of elder care, notably the Scandinavian model of universal state provision of LTC and the newly introduced German social insurance for long-term care (Campbell 2009: 71) because in the past "Japan had been undergoing two contradicting processes: towards universalism (health care for all), yet means-tested social security in other areas" (Campbell and Ikegami 2000: 29). On the one hand, in comparison to the German case, where the debate centered on the financial sustainability of the LTC insurance, in Japan the financial costs of introducing a social insurance system did not take the center stage. Instead, debates circled around who would be eligible, who would judge this eligibility and how citizens could repeal eligibility decisions made by the government (Campbell 1997: 2-4). Moreover, the system would have to be universal since, "[u]nder the resulting "Gold Plan," many people were already receiving many services (…) which made a severe approach to eligibility or benefits politically impossible" (Campbell et al 2010: 92). The Japanese were thus strongly in favor of a universal, non-discriminatory system of LTC.

On the other hand, while the Scandinavian model would have been a good solution to meet these claims, as Ikegami (2003) notes, "the fragmentation of health and welfare services, a general anti-bureaucratic mood and a corresponding interest in consumerism and market-based solutions, brought a search for a different way" (2003: 218). In these times of financial recession, the introduction of a new tax faced system sparked widespread opposition (Campbell et al. 2009: 70). The costs would thus have to be somehow shared between the state and individuals receiving care. As a result, as Ikegami et al. (2003) note, "the new programme has both taken the principle of open access from the health sector, and made more explicit the limitation of benefits according to eligibility from the social welfare sector" (2003: 219).

In 1997, the coalition government under the LDP, adopted the "Long-Term Care Insurance Act", which would come into effect in April 2000. As Campbell and Ikegami (2000) note, it took three years to implement the LTC insurance, firstly as the preparations for establishing such as system, particularly on the municipal level took a long time, and secondly because "LTCI suddenly got caught up in complicated interparty and factional politics surrounding the formation of a new three-party governing coalition and an upcoming general election (the worry was that voters might react strongly against having to pay a new social insurance premium)" (2000: 29). The coalition government, however, reached a compromise by putting a short-term freeze on premiums and subsidized this loss with extra-budgetary funds, and provided

a small means-tested allowance outside of the LTC insurance (Campbell and Ikegami 2000: 30; Campbell et al. 2009: 72-73).

The resulting LTC insurance resembles a mixture between the German social insurance and Scandinavian tax-based LTC: It financed to 50 percent by through taxes (25% national, 12.5% prefectural and 12.5% municipal governments), and 50 percent through insurance premiums. Municipal governments estimate their budget for a three-year term based on the estimated LTC demand; service prices are fixed by the national level (Olivares-Tirado and Tamiya 2014: 25, Tsutsui 2010: 376). In this "single scheme area-based-system (Tsutusmi 2014: 28), the premiums[7] of "primary insured" over 65 years are deducted from their pensions, while the "secondary insured" (40-64 years) pay in form of a payroll tax (Inamori 2017: 8). The insurance covers 90 percent of the costs, due to which the insured pay a co-payment of 10 percent (Olivares-Tirado and Tamiya 2014: 24).

An important difference to previous systems is that LTC financing has been unified at the central level (Ikegami et al. 2003: 218). Everyone over 65 years is eligible for LTC benefits, regardless of family members or income, while people aged 40-64 are only eligible for certain services (Shirasawa 2015: 232-233). The need of care is assessed by a computer questionnaire and qualitative assignments by evaluators, which assigns a person to one of six categories (Olivares-Tirado and Tamiya 2014: 28). As municipal governments are in charge of administration, a non-state organized municipal committee evaluates the materials and approves (or disproves) an application. Depending on the category, the insured can spend 500-3,600[8] USD on LTC services (limits at time of LTCI adoption in 2000), which are only provided in kind (Ikegami et al. 2003: 218), and organized by a "care manger" who writes care plans (Campbell and Ikegami 2000: 34). Yet, additional services can be purchased out of pocket. The Japanese government decided against using cash allowances (as in the German case) as one major aim of the policy was to reduce the caring burden on family members such as daughter-in-laws. Particularly, feminist groups opposed cash allowances, arguing that it would not improve the situation of female carers (Ihara 1997: 20-21). The "in kind" services take the form of institutional care or community-based care (including in-home care) and are provided either by the state and non-profit sector (as in the previous decades) or by for-profit, private LTC providers – a novelty in Japan. Private provision was allowed to enhance quality of LTC provision as the insured can choose between services (Shimizutani 2013: 8; 14-15). The Japanese LTC insurance system is summarized in Table 2 below.

[7] When the LTC insurance was established the premium was 0.9% of the monthly income of the 40-64 year-olds and 23 USD were deducted of pensions (65 years and over) (Ikegami et al. 2003: 219)

[8] The spending limits are increased every three years (Shimizutani 2013: 10-11).

Table 2: The Japanese LTC insurance system

Funding mix	50 % taxes (25% national, 12.5% prefectural and 12.5% municipal governments), and 50 % insurance premiums
Premium collection	"Primary insured" (65 years+) premiums are deducted from their pensions; the "secondary insured" (40- 64 years) pay payroll tax
Coverage	90% of the costs; 10% co-payment
	Depending on care category, my spend 500-3.600 USD on monthly LTC services (additional costs need to covered by insured)
Care categories	Seven categories (two preventive care, five long-term care)
Eligibility	Everyone 65+, 40-64 year old only in cases of old age illnesses
Application process	Care assessment via questionnaire and interview; final decision by municipal evaluation committee; care manager established "care plan"
Service Provision	In kind only, in form of institutional care, community-based care, or in-home care
	Mostly state and non-profit organization, slow development of private provision
Administration	Municipal governments

The major social policy change accompanying the LTC insurance is thus that "the LTCI scheme shifts the principle of elderly care from a means-tested public welfare programme ('Gold Plan') to a rights-based social care system run on the principle of social insurance" (Peng 2005: 84). Yet, since its establishment in 2000, major problems led to its revision. As the costs of the LTC insurance in 2013 were 2.61 times the amount spent in 2000, and is expected to rise, most importantly, the systems' financial sustainability is under jeopardy (Shirasawa 2015: 239-241). This is in part due to rising numbers of eligible service claimers - the coverage has increase from 6.9 percent in 2000 to 13.5[9] in 2008 (Olivares-Tirado and Tamiya 2014: 33) - and due to a rise in service costs. Amendments[10] have therefore tried to introduce preventive care in local community support centers (2005) and promote comparatively cheaper community-based services (2011) or outsourcing in-home care to "Integrated Long-Term Care Prevention and Daily Life Support Programs" (Inamori 2017: 17-18), as in-home care is the most-cost intensive service provision and accounts for 49.8 percent of the increase in LTC spending (Shimizutani 2013: 16). In addition to continuously rising premium levels, it is expected that higher income groups may have to make a co-

[9] Although in 2008 16.9 percent of the Japanese population were eligible, only 13.5 percent claimed services (Olivares-Tirado and Tamiya 2014: 33).

[1010] For a detailed account of the 2005 revision, see Japan's Ministry of Health, Labour and Welfare (2011).

payment of 20 percent in future and that admittance to institutionalized care will be increasingly restricted to persons with more severe disabilities (Shirasawa 2015: 239-240). According to Inamori (2017), the Japanese LTC system is therefore beginning to show signs of its former means-tested design since it is differentiating burden ratios on the basis of income levels, adding means-tested supplementary benefits as well as moving in-home care services to community support centres, resulting in benefit cuts (2017: 18).

The Case of South Korea: A Case of Policy Learning?

Similar to Japan, the South Korean society is equally witnessing a growing ageing population, a change in traditional family structures and values (Kwon 2004: 2; Choi 2014: 7) as well as economic decline due to the Asian financial crisis in 1997 (Kim and Choi 2013: 872). Yet, in contrast to Japan, the South Korean demographic change took a different turn: While the old-age dependency ratio during the 1990s and early 2000s was merely at 10 percent[11] and the average Korean life expectancy was not as high as in Japan (Seok 2010: 186, Choi 2014: 7), the very low fertility rate, which sunk to 1.08 on 2005 from 1.47 in 2000 (Choi 2014: 7), was the most significant alarm signal for political action (Kwon 2008: 121) – increasing the old-age dependency ratio to 15 percent in 2010 (Shin 2014: 73). Moreover, in contrast to Japan, South Korea could not look back on decades of elder care policy programs and infrastructure building, due to which South Koreans only had access to limited, means-tested state or non-profit LTC facilities (Kim and Choi 2013: 878; Seok 2010: 186). As there furthermore did not exist an extensive LTC infrastructure run by the third sector or religious organizations, there was no other option than to rely on care by family members (Seok 2010: 188).

Whereas public debates on the need to establish a LTC financing scheme and infrastructure were largely absent, it was the government under Kim Dae-Jung who started promoting greater social security in all areas, including the LTC (Choi 2014: 8). Among others, he merged 350 health social insurance agencies into one National Health Insurance Corporation (NHIC) (Campbell et al. 2009: 76). Subsequently, after Kim established a Planning Committee for Long-Term Care for Older Persons in 2000, he first publicly suggested the implementation of a LTC social insurance in 2001 (Kwon 2009: 28). In addition, at the time the Korean Institute for Health and Social Affairs (KIHASA) commenced a working paper series on LTC schemes and financing (Campbell et al. 2009: 75). By 2002, the Kim establishment had promised the introduction of a new LTC financing scheme, making it an electoral commitment (Choi 2014: 8).

[11] As Seok (2010) notes, while Japan and Germany for instance adopted their LTC schemes when they reached an old-age dependency ratio of 17 and 18 percent respectively, South Korea took this step much earlier in anticipation of a rapidly aging society (2010: 186).

Following the elections of 2003, the new president Roh Mu-Hyun, a member of the same party as Kim (Campbell et al. 2009: 75) continued his predecessor's plans and announced he would launch a new LTC financing scheme by 2007 (Kwon 2009: 28). To achieve this aim, he set up a "Task Force Team to Guarantee Elderly Long-Term Care" within the Ministry of Health and Welfare, which consisted of civil servants and representatives of the public. This Task Force was put in charge of discussing potential frameworks and operating measures for a future LTC scheme from 2003 to 2004. Finally, the Roh administration set up a number of pilot projects[12] between from July 2005 to July 2008 to test social insurance schemes, before the Elderly Long-Term Care Insurance Law was passed by the National Assembly in April 2007 (Seok 2010: 186-187). As Kwon (2008) remarks, Roh had a strong incentive to establish a LTC financing scheme as soon as possible due the upcoming elections in which the vote of the elderly would be of vital importance (2008: 130). In comparison to Japan, it was thus the combined effort of two presidents who pushed for the introduction of LTC, which points to the strong power concentration in the hands of presidents and the majoritarian electoral system in South Korea (Estévez-Abe and Kim 2016: 15-16).

While these two succeeding governments were pushing the LTC financing scheme forward, non-state actors such as civil society groups, trade unions or other interest groups did not much engage in the discussion until the introduction of the LTC insurance (Kim and Choi 2013: 880; Seok 2010: 187). In contrast to Japan, the feminist movement, for instance, is said to not have played a crucial role in discussing how the new LTC financing scheme should operate (Kwon 2008: 131; Seok 2010: 194), although Estévez-Abe and Kim claim that while feminist groups were focusing on mobilizing for child care, they also addressed LTC, albeit to a lesser extent (2016: 15). The medical association was also less concerned about the particularities of the LTC financing scheme, but more interested in securing a prominent role in the assessment of elderly for the program (Kwon 2008: 132). Ultimately, as Kim and Choi (2013) point out "it was the government that began to raise the LTC issue as a policy agenda item, that dominated the legislation process, and that implemented the programme as scheduled, whereas media and even interests groups were not much interested in the LTCI (2013: 881).

In the discussion concerning what form the LTC financial scheme should take, the Ministry of Health and Welfare (MHW), the new NHIC as well as the Ministry of Finance and Economy (MFE) were all in favor of a social insurance. The MHW promoted a LTC social insurance scheme as it, similar to the health insurance, would be under its control and thus enlarge its power and capacity (Kwon 2008: 127, Kim and Choi 2013:

[12] The Roh administration initiated several small-scale pilot programs on LTC social insurance in six locations across South Korea, mainly for the elderly poor, in order to assess the needs of the elderly (mainly ADL and IADL) and the delivery system – and thus not the sustainability and functioning of the financing (Kwon 2008: 133).

881). Similarly, the newly founded NHIC supported the LTC as it saw it "as an opportunity to extend its own operation and mitigate against the pressure of downsizing/employment adjustment within its own organization" (Kwon 2009: 28). The MFE, in turn, favored social insurance as it was wary of introducing new taxes, which would lead to an additional strain on governmental budgets (Kwon 2008: 127; Kim and Choi 2013: 881). The MFE furthermore worried about the potentially this additional financial burden "will have a negative effect on the economy facing fierce global competition" (Kwon 2008: 133). In addition, as Kim and Choi (2013) remark, once the Ministry of Health and Welfare published its policy draft, many political actors, interest groups and care providers became increasingly interested in the issue and started promoting the development of LTC insurance (2013: 882). For this reason, as Campbell et al. (2009) note, "A possible reason for the lack of resistance was that the proposals were so well received by the general public that it could be politically risky to oppose them" (2009: 76)

The political and public support to establish a LTCI could also be based on policy legacies and challenges associated with other areas of Korean social welfare. On the one hand, South Korea had established a universal social insurance scheme for health care in 1988 (Campbell et al. 2009: 74), providing the Korean government with social insurance-related expertise and an administrative infrastructure which could be used to manage the LTCI in future (Kwon 2008: 127-128; Chon 2014: 708). Yet, this health care provision was ridden with financial problems (Shin 2014: 70). Firstly, despite its universal coverage the health insurance only covered 60 percent of health care expenditures, leaving 40 percent of the medical expenses to out-of-pocket payments. Secondly, increasing public reliance on the health care system to provide LTC benefits, was creating a financial strain on the system (Kwon 2008: 128; Campbell et al. 2009: 75) which was already suffering from high-cost medial services largely provided by the private sector (Seok 2010: 190). In 2000, the health care system therefore experienced a financial deficit and needed to be rescued by the IMF (Kwon 2008: 128). On the other hand, as a result of the financial crisis in 1997 the pension system was extended to the urban self-employed in 1998 (Campbell et al. 2009: 75). With a high elderly poor rate of 45 percent in the 2000s (Kim and Choi 2013: 879), the South Korean welfare system overall was thus suffering from a lack in governmental and private funds to purchase LTC services. With its knowledge of social insurance schemes and lack of public funding, a LTC insurance scheme thus seemed to be the most cost-effective alternative.

Ultimately, the Long-Term Care Insurance for Older People Act took effect in July 2008 (NHIS 2017; Chon 2014) and covers everyone over the age of 65, as well as younger insured, who suffer from LTC-related illnesses - although disabilities are not covered (Sunwoo 2012: 51). It is to 60 percent financed by social insurance contributions, 20 percent is subsidized by taxes and 20 percent is covered through co-payments

(Chon 2014: 708). The social insurance premium is deducted as a percentage of the health insurance premium (4.05%) from monthly payrolls (Kwon 2009: 29). All LTC benefits are covered up to a benefit ceiling which depends on the care level, although the insured has to make a 20 percent co-payment in case of institutional care, and 15 percent when receiving home-based care (Chon 2014: 708). Means-tested LTC is free, while 50 percent of the costs are waived for users in the "second-poorest class". To finance this means-tested LTC, the government publicly funds 30 percent of the costs (Seok 2010: 194).

Turning to the benefits and service provision, most benefits are provided in kind in form of institutional or community care, whereas cash allowances are only available in exceptional cases. The focus on in kind services is less based on a feminist critique of such, as in Japan, but more on the governmental objective to relieve women from long-term care burdens (Kwon 2008: 131) – a potential move to increase fertility. Benefits are provided up to certain ceilings[13], which are calculated by the taking into account the care level and type of benefit (Kang et al. 2012: 43). In comparison to Japan, benefit levels are much less generous (Campbell et al. 2009: 77). Services are largely provided by the private sector (Sunwoo 2012: 55), which has even been argued to have created an oversupply of LTC services (Seok 2010: 2000). In contrast to Japan, local governments do not engage in provision or financing of LTC. Instead the NHIC in charge of administering LTC financing and assigning insured to one out of six benefit levels (Choi 2014: 14). To determine eligibility for benefits, after filing an application with the NHIC, a team of the local branch of the NHIC, which assigns an individual in one of three care levels according to a questionnaire and an interview (Kang et al. 2012: 42). Finally, in 2013, the system covered 6.1 percent of the population aged 65 and older (Choi 2014: 9). Table 3 summarizes the Korean LTC insurance system.

[13] While monthly costs for community care are capped between 784 and 1,196 USD, costs for institutional care are limited between 1,359 and 1,768 USD (1,000 Won = 1 USD) (NHIS 2017).

Table 3: The Korean LTC insurance System

Funding mix	60% insurance premiums, 20% co-payments and 20% taxes
Premium collection	Insurance premium is deducted as a part (4.05%) of the health insurance payroll tax
Coverage	80-85% of the costs are covered; 20% (institutional care) and 15% (home-based care) co-payment; additional means-tested and subsidized LTC provision
	Depending on care category, my spend 784 and 1,196 USD on monthly LTC services
Care categories	Six benefit levels
Eligibility	Everyone 65+, as well as younger citizens who are suffering from old age illnesses
Application process	Care assessment via questionnaire and interview by NHIC
Service Provision	Mostly in kind, cash allowance in exceptional cases; in form of institutional care, community-based care, or in-home care
	Mostly provided by private provision
Administration	National Health Insurance Corporation

The South Korean LTC system is thus the result of presidential system and government-induced reform (Kim and Choi 2013: 880). As Kwon (2009) notes, the "LTC insurance had been proposed, and indeed was ultimately implemented, by a series of progressive governments that strongly supported the expansion of the welfare state" (2009: 28). The result is a LTC financing scheme which has Japanese and German features: While its benefit scheme resembles the Japanese LTC system, its operational structure mirrors German model (Seok 2010: 194). Although policy learning effects may have played a role, as in South Korea's use of a questionnaire to assess eligibility which is similar to the case of Japan, it appears that it was domestic policy actors and scientific evidence which triggered the implementation of the South Korean LTCI (Campbell et al. 2009: 78). Ultimately, this change in policy has initiated welfare state change in Korea as "Implementing the LTC programme through social insurance has been required to break up two crucial institutional legacies in the Korean welfare state: the selective nature of social service provisions and forced dependency on the family" (Kim and Choi 2013: 880).

The Case of Taiwan: Taking a Different Route

Similar to Japan and South Korea, during the 1990s, the Taiwanese government became increasingly aware that a decline in the fertility rate, female labour market participation and longer life expectancy was leading to a growing elderly population in need of long-term care (Chiu 2002: 217; Lin 2010: 148, Wang and Tsay 2012: 466). In 1993, when Taiwan's population of 65+ years reached seven percent of the population – the marker according to which the UN classifies a population as "aged" (Chiu 2002: 217), this marker seemed to have functioned as a "wakeup" call (Lin 2010: 148). Its old-age dependency ratio quickly rose to 10.6 in 2010 (Wang and Tsay 2012: 466) and is expected to reach 24.1 percent in 2030 (National Development Council 2016). As in Korea, the rate of population ageing is thus comparatively high. At the same time, Taiwan, however faced a number of challenges in financing and providing elder care. On the one hand, as the previous authoritarian government[14] under KMT rule (Kuomintang, the Nationalist Party) had targeted social security at economically productive societal groups to obtain their political support, economically vulnerable groups were excluded from state welfare. The National Health Insurance at the time, for instance, was segmented according to occupational groups and only covered 51 percent of the population (Lue 2014: 278). On the other hand, although the Taiwanese government under the KMT set out to universalize many realms of social security during the democratization process in the 1990s (Lue 2014: 277-278), including the pension and health care systems, growing financial difficulties hampered this development. As Lue (2014) notes, during the early 1990s, "one-quarter of government spending was financed by borrowing. (…) Although borrowing has declined since 1998 due to a series of austerity measures, the financial structure remains a serious issue" (2014: 282).

As a result of this segmented social security system, Taiwan's LTC system is strongly fragmented. Firstly, the Ministry of Civil Affairs and its local agencies largely provide community-based and in-home care services for the means-tested elderly, as a part of their public assistance program. These services are provided by non-profit state and third sector LTC providers (Chiu 2002: 221-222). Secondly, the Ministry of Health who started to become active in LTC in 1995, covers institutional LTC care and in-home services as a part of its national health insurance. In cases of severe impairment (i.e. must be bedridden over 50% of the time) or chronical illnesses, elderly can receive care in chronic hospitals or nursing homes (since 1991), should they obtain a referral from their physician. Again the provision is mostly public (Chiu 2002:

[14] After the Nationalist Party (KMT) had been defeated by Mao Zedong on mainland China, they had fled to Taiwan, establishing an authoritarian government on the island. Martial law which had been enacted in 1949 continued until 1987, when the KMT initiated a democratization process which opened seats in parliament in 1991 and initiated the first presidential election in 1996 (Hermanns 2009: 211).

225-226). Thirdly and finally, the Veterans Association provides LTC care in veterans homes and chronic illness hospitals for former military staff (Chiu 2002: 226). While there are private care institutions, they are not allowed to make profits or advertise their services aggressively (Wang 2011: 171-172). Families who are not covered by public services or cannot afford private institutions therefore increasingly hire foreign care workers or make use of non-registered (quasi illegal) nursing homes which provide LTC at lower costs, albeit not being subject to quality control (Chen 2015; Chiu 2002: 224).

With the democratization underway and first presidential elections in 1996 (Hermanns 2009: 221), government provision of social security became an object of party competition. Lue (2014), for instance, notes that

> (…) the intermediate institutional mechanisms between economic globalization and social policy development is characterized by political conflict between two dominant parties rather than consensus building. Political competition pushes social demands to the centre of the political agenda, forcing the two dominant parties to respond" (2014: 282)

After Lee Tenghui of the KMT was enacted as president in 1996 (Wu 2005: 38), the KMT administration issued a "Plan for Improving Caregiving to the Elderly" and a "Three-Year Project for Long-term Care for the Elderly" in 1998 – developed by the Ministry of Health (Lin 2010: 153-153). The Three-Year Plan sought to consolidate the fragmented LTC system, encourage training of LTC personnel, raise awareness and enhance quality of LTC services. Yet, as the plan did not include solutions to the limited financial resources and continuing systemic segmentation, the plan in fact strengthened competition between governmental agencies, resulting in reduced accessibility and effectiveness (Chiu 2002: 227).

When the main opposition party, the Democratic Progressive Party (DPP) under Chen Suibian, won the subsequent elections in 2000, they sought to enhance their popularity by further reforming the LTC system. After setting up a pilot program in 2000, they created a plan for the development of care services in 2002, commissioned a LTC Task Force in 2005 and, most importantly, issued a Ten-Year Plan for LTC in Taiwan in 2007 (Lin 2010: 153-154). Moving away from the solely means-tested LTC provision, the Ten-Year Plan foresaw universal, non-means-tested LTC provision at the community level provided by LTC management centers in every city. The centres would act as a point of "single-window service delivery", centralizing LTC services (Wang 2011: 173; Wang and Tsay 2012: 466). The DDP's plans and policies thus for the first time provided the prospect of universal LTC in Taiwan. As Estévez-Abe and Kim (2016) note, the DPP's strong support of universal LTC could be due to a change in electoral rules in 2005. While the electoral system had been based on a "combined single non-transferable vote and multi-member district" (SNTV-MMD) which provided an incentive to cater to sub-groups within local electorates, the electoral reform abolished

this system and introduced a two-tier mixed system of single member districts and proportional representation (Estévez-Abe and Kim 2016: 17).

After the KMT resumed office in 2008, it quickly declared that it would bring the implementation of the Plan to a halt and "that the Long-Term Care Insurance (LTCI) would supplant the Ten-year Plan for Long-Term Care in 2010 because of financial load-shedding and business opportunities" (Lin 2010: 157). The KMT thus attempted to outplay the DPP's plan by introducing LTC insurance. As Nadash and Shih (2012) note, the KMT's policy proposal had been drafted by a think tank associated with the executive branch, the Council for Economic Planning and Development. It was then accepted by the Executive Yuan in 2009 and further developed by the Ministry of Health and Welfare (2012: 2). However, although the KMT was advocating the socialization of LTC to relieve family burdens, both parties (KMT and DPP) regarded the development of LTC as an opportunity to enhance economic development (Wang and Tsay 2012: 466). While feminist groups and senior interest groups were said to be actively promoting the extension of LTC system (Wang 2011: 173), pressure groups in general have very limited impact on policy reform in Taiwan (Nadash and Shih 2012: 3). Public opinion, furthermore, was strongly in favor of a universal LTC financing scheme (Nadash and Shih 2012: 6).

The introduction of these LTC policies and plans is strongly linked to developments in the broader social security system. Ever since the KMT had implemented a reform of the National Health Insurance (NHI) in the 1990s, making it universal in 1995 (Wang and Tsay 2012: 466; Lue 2104: 277), the NHI had been in the focus of electoral competition. Through this first universal social welfare system, Taiwanese elderly had gained access to some form of LTC provision. However, the growing health care and LTC provision increased NHI costs rapidly, leading to a financial deficit in 1998 (Lin 2010: 153-155). After being elected to office in 2000, the DPP attempted to reform the NHI, by for instance issuing a "Second Generation NHI" plan. Yet, the DDP's plans were strongly resisted and blocked by the KMT, only to be re-proposed as a solution by the KMT in 2010 (Lin 2010: 155). While health care had become universal and was in the spotlight of debates, the DPP furthermore attempted to introduce a universal pension insurance[15] in 2007. This system, however, remains fragmented and has been amended eight times since the KMT took power (Bureau of Labour Insurance 2017a, b). Ongoing political struggles therefore explain why "the expansion of the Taiwanese welfare system has been accompanied by continuing gaps in provision, and in particular why health insurance has become universal while pensions system has remained fragmented and social assistance rudimentary" (Lue 2014: 280).

[15] For further information on the debate and development of the pension insurance see Lin 2010: 160.

Political struggles furthermore appear to be the reasons for the deferral of implementing the LTC insurance. As Lin (2010), for instance, notes "the undecided policy due to the rotating power of different parties is a large reason for the deferred development of this national long-term care system" (2010: 158). Although the KMT started to draft an LTC insurance bill after coming to power in 2008, it was discussed in parliament for seven years, before a draft law was issued on 4 June 2015 (to be implemented by 2018) (Cheng 2016; Zeldin 2015). A major reason for the delay is the fact that the Legislative Yuan is commonly used by the party in opposition to block or delay policy reforms (Nadash and Shih 2012: 3). Furthermore, the KMT and DPP had long disagreed over how to fund the service provision,[16] ultimately agreeing on a new tabacco tax (Nadash and Shih 2012: 7). Finally, the KMT government first wanted to improve the LTC infrastructure before setting up a LTC financing scheme by implementing a complementary LTC service law, which was adopted in May 2015 (Cheng 2016; Zeldin 2015).

The LTC Insurance draft law is based on a PAYG system, which is co-funded by the employer (40%), the employee (30%) and the state (30%) – thus demonstrating similarities to the German system. Employees pay a premium of 1.19 percent which is subject to increase every three years (Ministry of Health and Welfare 2015a; CNA 2015). The insurance will cover LTC costs up to a certain ceiling (the ceiling was not specified in the Law), however, the insured need to contribute a 10 percent (capped) co-payment and any costs associated to lodging and food in institutional care arrangements are not covered (Ministry of Health and Welfare 2015b, Nadash and Shih 2012: 6-7). In principle everyone is eligible to obtain LTC if he or she has been in continuous care due to physical or mental illnesses. A questionnaire then assigns the applicant to one of four care levels, while the final decision lies with a LTC Committee comprising insured, employers, administrators and experts. Services are provided in cash as well as in kind according to a LTC care plan (Ministry of Health and Welfare 2015a, b). Although Taiwan is said to have a strong feminist movement and many femocrats in government (Estévez-Abe and Kim 2016: 16-17), the provision of cash allowances could be based on the strong reliance on foreign care workers in Taiwan (Estévez-Abe and Kim 2016: 17). Finally, whereas the administration is led by central and local governments and public providers exist, provision is mostly private (Nadash and Shih 2012: 3). The basic features of the Taiwanese LTC system is outlined in Table 4 below.

[16] While the KMT wanted to use public coffers, health surcharges on tobacco, donations, interest from the fund, and other sources to fund the LTC service, the DPP had pushed for an increase in inheritance and gift taxes (US Congress).

Table 4: Taiwan's LTC Insurance System

Funding mix	40 % employer, 30% employee and 30% taxes
Premium collection	Premium is collected as a payroll tax (1.19%)
Coverage	Covers costs up to a ceiling, does not cover "dormitory costs" and "food costs" in institutional care arrangements
	Depending on care category (no budget ceilings decided yet)
Care categories	four categories
Eligibility	Everyone who has been in continuous need of care due to physical or mental health (at least 6 months or longer) is eligible
Application process	Questionnaire; final decision by LTC committee comprising insured, employers, LTC administrators and experts
Service Provision	in kind as well as cash allowances, in form of institutional care, community-based care, or in-home care; service provision according to care plan
	Mostly private provision
Administration	Ministry of the Interior and Ministry of Health and Welfare (central government), Department of Social Affairs (local government)

Nevertheless, these features may be subject to change. After the DPP regained power in 2016, it amended the LTC service Act (now: LTC Service Act 2.0) and issued a new tax to fund LTC service provision in January 2017 (Executive Yuan 2016). Furthermore, while the DPP supports the LTC insurance (Taipei Times 2015), it may amend the LTC insurance Bill in future. In sum, since the issue of LTC had been linked to the hotly debated issue of universal health care and was taken up by both parties as a means to win elections, the Taiwanese government has opted for a universal LTC insurance scheme to finance LTC. The result resembles an "institutional bricolage" (Cleaver and de Koning 2015) of various institutions and policies, as it combines the German tripartite funding mix, Japanese questionnaire and care plans as well as Korean emphasis on developing the private sector. Moreover, both major parties appear to view LTC provision as an opportunity to enhance economic development, having the potential of becoming a "key industry" in the long-run (Wang and Tsay 2012: 466). In contrast, many other parts of the Taiwanese welfare system remain to be fragmented and means-tested.

Comparing Historical Trajectories of LTCI Systems

The case studies show that while policy learning played a role in designing policy solutions to the growing aging population, electoral and political systems as well as financial pressure appear to be the major reasons for the countries to implement LTC social insurance systems. While Japan had already attempted to introduce universal taxed-based LTC through its Golden Plan, the failure of this plan and the growing financial and demographic pressure led to social insurance schemes being seen as the most appropriate policy solution. Furthermore, policy legacies, most importantly the universal tax-based health care seemed to have provided the impetus of introducing a financing scheme which is to 50 percent funded through taxes. It appears that in Japan the early promise of universal LTC combined with previous policy failures had created feedback effects which provided the government(s) with only one option: implementing social insurance. In contrast, both the South Korean and Taiwanese government were undergoing democratization processes and could not look back on a long tradition of social security. Struggling with a financially unsustainable health care insurance and comparatively high old age poverty, reforms in South Korea appear to have been rather driven by public and private difficulties in financing and providing LTC. Due to the high financial pressure, the costs of LTC provision is mostly covered by the insured, since he or she bears 80 percent (60% premium, 20% co-payment) of the costs. Taiwan shows similarities to South Korea, as it equally had only started to expand its social welfare system in the 1990s by drawing on social insurance models and its health insurance scheme was running deficits. Yet, instead of following the Korean approach, Taiwan will implement a tripartite financing scheme which distributes the costs among the employers, the employees and the state. Due to policy legacies and financial pressures it thus appears that both the Korean and Taiwanese government regarded tax-funded scheme unsustainable and potentially less-compatible with their existing welfare state institutions due to which they opted for a social insurance solution.

In making this decision, all three governments seemed to have selectively adopted or emulated elements of foreign LTCI schemes. Yet, while Japanese policy makers at the time studied and learned from the German and Scandinavian model, discussions on introducing an LTCI had begun before the adoption of the LTCI in Germany. Moreover, as the financing scheme and coverage of the Korean and Taiwanese system furthermore strongly differ from the Japanese system and from another, it appears that the latter two cases cannot simply be explained by policy learning processes, although certain procedural and technical elements seem to have been emulated such as the use of a questionnaire or care plans.

The most important impetus for the adoption of LTCI systems, however, came from the state. In Japan, electoral politics had made universal LTC, at least in principle, available to Japanese citizens. After the reform of electoral rules in 1994 increased party competition, LTC became subject to competition between the main parties. As both Keigo Ouchi from the Social Democrat Party as well as Hashimoto Ryûtarô from the Conservative LDP subsequently supported an LTC insurance during their time in office, it was adopted in 1997. In Korea, it seems to have been less a case of electoral competition but rather the reform will of two presidents, Kim Dae-Jung and Roh Mu-Hyun, who used the concentrated power offered through the presidential system to push through a number of reforms. In comparison, Taiwanese LTC reforms have been strongly influenced by party competition - as it appears to an even stronger degree than in the Japanese case. The electoral reform in 2005 provided an impetus for the two dominant parties to advocate a universal LTC system. As the health care system's crisis had been in the focus of attention and the KMT and DPP were fiercely competing for voters, introducing a LTC social insurance presented an appropriate solution. The reforms thus appear to be rather government-induced than promoted by non-state actors. Although feminist groups in Japan were influential in pushing for an "in kind only" provision, most interest groups appear to have been less interested in LTCI systems. A comparison of the three cases is illustrated in Table 4:

Table 4: Comparing East Asian LTC insurance schemes

	Japan	**South Korea**	**Taiwan**
Time of introduction	1997 (2000)	2007 (2008)	2015 (2018) (before draft law)
Funding mix	45% taxed-based, 45% contribution, 10% co-payment	20% taxed-based, 60% contributions, 20% co-payments	40% employer, 30% employee, 30% tax-based
Premium collection	Payroll tax or deducted from pensions	4.05 of health care payroll tax	1.19 Payroll tax
Coverage	90% of all costs	80-85% of the costs are covered	n/a
	generous benefit ceilings (up to 3,600 USD)	all costs (except food), less generous benefit ceilings (up to 1,196 USD)	least generous benefit ceilings (no cover of lodging and food)
Care categories	Seven categories	Six categories	Four categories
Eligibility	65+, to less extent 40-64 years	everyone	Everyone

Application Process	Questionnaire, final decision made by non-state committee	Questionnaire, final decision made by NHIC committee	Questionnaire, final decision made by state and non-state committee
Service Provision	In kind (care plan)	Mostly in kind (some cash)	In kind and in cash (care plan)
	Mostly state and non-profit, slow development of private sector	Mostly private	Mostly private
Administration	Local governments	National Health Insurance Corporation	Central and local governments

Comparing the explanatory power of the theory-based factors mentioned above, the party and electoral system, the policy legacies as well as the financial pressures thus seem to have played the most crucial roles in the introduction of a LTC insurance scheme. While the Japanese and Taiwanese reforms were facilitated by party competition, the concentrated power of Korean presidents enabled the adoption of an LTCI. Furthermore, in all cases the increasing reliance on universal health care systems to provide LTC contributed to the urgency of introducing reforms, which often took the shape of the existing institutional landscape (in Japan partly taxed based, while in Taiwan and Korea social insurances were preferred). While policy learning did play a role in all cases it is difficult to distinguish to what extent each country learned from other models – a common difficulty in policy transfer theory (Dolowitz and March 2000: 6). Furthermore, while civil society groups were in part active, they seem to have been mainly involved in supporting policy options already proposed by politicians or bureaucrats. Finally, the cross-case comparison also shows that the magnitude of the financial and demographic challenges in each country does not allow for a prediction of which financial mix will be used. Although Japan was facing financial difficulties after the Asian crisis, it nevertheless introduced a strongly tax-based system, while both the Korean and Taiwanese system rely on higher contributions. Yet, here again the Korean system puts the responsibility on the insured while in Taiwan a tripartite funding scheme will be put in place. Similarly, the level of the old-age ratio and fertility rate do not provide any clue as to what timing the three governments adopt LTCI schemes.

Conclusion: Is the "East Asian Welfare State Model" in Decline?

The remaining question is whether the introduction of universal LTC insurance scheme resembles a shift in the logic of the examined East Asian welfare states. While these systems in the past had been

characterized by low state expenditure and the use of social policies for the sake of economic development (White and Goodman 1998; Kwon 2009), the introduction of universal LTC insurances, which are partly tax funded, on the surface does point to a turn towards more de-commodifying social policies. Yet, when examining the schemes in detail it becomes apparent that the LTCI systems do not deviate that much from the overall systemic logic. Particularly, the South Korea and Taiwanese systems to a large extent put the financial burden on the insured by making it mandatory to save for future LTC service needs, and insurance coverage is rather low. Furthermore, while the Japanese LTCI started off as the most de-commodifying of all three cases, financial pressures are resulting in a gradual return to more means-tested benefits.

In sum, while all three governments invest public funds in LTC insurance and infrastructure building, it appears that the LTCI systems have been firstly introduced to prevent future strains on the public budget and secondly to develop LTC provision, or the "silver industry", into a pillar industry in future. Both of these aims – reducing costs and promoting silvery industry development – in combination with only weakly de-commodifying social policies are thus in line with productivist welfare state logic. Although this paper supports Kwon's (2005) remark that productivist features "have become 'more inclusionary' than they were during the previous decade", it is therefore questionable whether the introduction of LTCI systems in these countries has sparked a shift away from the East Asian welfare model.

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