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**Article:**

Oh, K.M. and Warnes, A.M. (2001) Care services for frail older people in South Korea. *Ageing and Society*, 21 (6). pp. 701-720. ISSN: 0144-686X

<https://doi.org/10.1017/S0144686X01008479>

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## Care services for frail older people in South Korea

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### **ABSTRACT**

This paper examines the changed social circumstances of older people in South Korea and specifically the increased need for formal health and social services for those who are frail and have no informal carers. The article begins with a summary account of the country's exceptionally rapid demographic, economic and social transformations, which demonstrates a widening gap between the population's expectations and needs, and health and social service provision. It then examines the recently initiated and now burgeoning welfare programmes, with particular attention to health and social services for sick and frail older people. Most extant care services are accessed mainly by two minorities: the very poor and the rich. The dominant policy influence of physicians and a history of conflict between traditional and western medicine probably underlies the low current priority for 'care' as opposed to 'cure', as also for the management of chronic conditions and rehabilitation. Neither long-term care services nor personal social services are well developed. There is a marked disparity between the acute services, which are predominantly provided by private sector organisations in a highly competitive market and broadly achieve high standards, and public primary care and rudimentary residential services. The latter are weakly regulated and there are many instances of low standards of care.

**KEY WORDS** – Inter-generational relations, informal care, health services, social services, South Korea.

### **Introduction**

This paper examines the implications of the radical and exceptionally rapid changes in the demography, economy and social formations of South Korea during the last few decades for the care and support of frail older people. It describes a widening disparity between older people's service needs and available services, and makes a case for changed investment priorities. As in other south-east Asian countries, modernisation and industrialisation have been accompanied by a wholesale change in occupations and values, and the spread of

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secondary and higher education. This has brought a revolution in aspirations and expectations and, specifically, a declining willingness of adult children to co-reside with their parents and, if one or both are frail, to be their principal carers. The complement has been an increasing need for both domiciliary and residential formal care services for physically and cognitively impaired older people. While South Korea's health and social services have developed considerably during the last few decades, the focus has been on acute hospitals and primary care, while community health and personal social services and long-term care remain rudimentary.

The pace of change in the nation's economic and social formations and in the circumstances of its older people are unprecedented and have few contemporary parallels (OECD 2001). From the 1950s to the 1990s, South Korea had the largest gain in life expectancy of any OECD country. If however the global trend of the last century continues, whereby the later a country entered the 'demographic transition' from high to low rates of fertility and mortality, the faster it has been completed, then over the next few decades many other countries will follow South Korea's path, and its speed of change may be surpassed. The responses to tumultuous economic growth of both the peoples and the governments of countries like South Korea are therefore of wide relevance for the prospective social circumstances and quality of life of the majority of the world's older people who live outside the richest, westernised nations.

There are three features of special interest in South Korea. As in other east Asian countries, there is a strong cultural tradition and repeated affirmation of the values and practices of 'filial piety'. Among its many expressions, it leads governments to assert that the family is and should be responsible for the material support and care of older people, and therefore to claim that it is not necessary to develop social security old age income systems or formal care services for frail older people. Secondly, the enthusiastic pursuit of a capitalist model of economic development with strong influences from the United States and Japan has encouraged even South Korea's responsible governments (a number since the 1950s have been corrupt) to argue that their primary responsibility is to create a legal and fiscal environment that is conducive to business, which translates into low personal and corporate taxation and a minimal welfare state. Thirdly, the clear contradictions between socio-economic ideologies and the changing circumstances of family members of both working and old ages, has led to a widespread critical debate about the ideology of filial piety, as well as a strong empirical research focus on trans-generational mutuality,

reciprocity and living arrangements. This is beginning to yield insights into the adaptability of inter-generational relations that go beyond the understandings acquired by gerontological research in the English-speaking world and in Europe.

### **The demographic and socio-economic background**

In 1998 South Korea had a population of 46.4 million at a density of 467 people per square kilometre which, excepting city-states, is one of the highest in the world (OECD 2000). For example, its density is 12 per cent higher than that in The Netherlands. Over the last 30 years, South Korea has had one of the most rapidly growing economies in the world: its per capita GNP of \$82 (US) in 1961 was among the lowest, but it had increased to \$10,543 (US) by 1996, in which year the country joined the Organisation for Economic Co-operation and Development (OECD), a mark of 'developed' country status (Oh 1999: 225). The country has recovered from the 1997 financial crisis, 'with output increasing nearly 11 per cent in 1999 and nine per cent in 2000' (OECD 2001: 8). Industrialisation and modernisation has been accompanied by substantial decreases in both fertility and mortality, which have brought rapid increases in both the absolute and relative numbers of older people. The population share aged 65 and more years in 1966 was just 3.3 per cent but, by 2000, it had reached 7.1 per cent, and it is expected to be around 13.1 per cent in 2020. The speed of the 'age structure transition' has been much faster than in European countries or Japan. In France the corresponding share reached seven per cent of the population in 1865, and the same point was attained in the United Kingdom in 1930, in Japan in 1970, and in South Korea by 2000. Thus whilst the doubling of the share took 115 years in France, 45 years in the UK and 24 years in Japan, it is expected to take just 22 years in South Korea (Table 1).

The absolute number of people aged 65 years or more has recently increased rapidly, from approximately 1.45 million in 1980 to 3.0 million in 2000, as a result of the formerly high birth rates and improved survival. A further doubling in the next 20 years is projected, but if the current low level of fertility persists, the rapid growth will draw to an end from the middle of the century. It has not however been primarily the increasing number of older people that has produced a growing need for formal care services. More important have been the concurrent changes in the nation's occupational structure, household

TABLE 1. *Duration of the age structure transition in five countries*

Country	Year in which the share of the population aged 65 years or more attained:		
	7 per cent	14 per cent	Interval (years)
South Korea <sup>1</sup>	2000	2022	22
Japan	1970	1994	24
United Kingdom	1930	1975	45
France	1865	1980	115
Sweden	1890	1975	85

Source: Before 1940: UNO (1956). After 1940: UNO (1991).

<sup>1</sup> Source: Chung (1998).

arrangements, educational system and normative values which, among other things, have altered the availability of informal carers for those who are disabled or ill. The process of modernisation has subsumed more specific transitions associated with urbanisation and industrialisation. As recently as 1955, only one quarter of the population lived in urban areas. By the late 1970s a majority did so and, by 2000, around four in five will (Keyfitz and Flieger 1990: 226).

The country's welfare system has four 'pillars': national health insurance (from 1989), a national pension scheme (1988) that will begin paying regular pensions in 2008, public assistance (educational and medical benefits covering the poorest 4.5 per cent of the population, from 1993), and industrial accident assurance (from 1962) (Kwon 1997: 469). There is no state unemployment benefit although, in the wake of the 1997 financial crisis which led to a sharp growth of poverty, 'the government recently announced comprehensive measures to strengthen the social safety net [with] particular emphasis on laid-off workers' (MOHW 2001):

In 1995, the public and private sectors in South Korea respectively spent 10 and 1 per cent of GDP on social protection ... the public assistance programme provides no more than a very basic universal safety net, and all other programmes cover only those who have paid into them. (Holliday 2000: 713).

There have been many attempts to account for the country's distinctive income support policies and programmes, with a clear shift over the last decade from 'cultural' to 'statist' explanations (Kwon 1997, 1999). Another recurrent interest has been to establish the similarities and dissimilarities of South Korea's welfare programme to those of both the other ASEAN 'economic tigers' and the two most similar European countries: Austria and Germany. In the terminology of Esping-

Andersen (1990), the latter exemplify 'conservative welfare regimes' that emphasise insurance principles, support for employed men and their families and cash transfers, but do not develop widespread social services or attempt income redistribution. Holliday (2000: 707) has argued that the distinctive feature of the east Asian 'productivist' welfare model is that it consistently subordinates social policy to macroeconomic and economic growth goals. If the early phases of public welfare development in all countries focus on the alleviation of poverty and educational and health policies targeted on children, in part to raise the quality of the labour force, modernisation accompanied by decreased fertility, smaller households and increased longevity gradually change the balance of needs. Attention to improving the quality of life of older people becomes a public health priority and a politically expedient goal. The creation of such a 'threshold of need' for formal care services for frail older people in South Korea and the early responses are the focus of this paper.

### **The changed social circumstances of older people**

Since the 1960s, the life-styles and aspirations of the South Korean people have markedly changed, with important consequences for older people's position in society and the sources of their material and instrumental support. Until recently and for many generations throughout east Asia, the acceptance and practice of filial piety greatly influenced the relationship between older parents and adult children (Knodel *et al.* 1992; Martin 1989). Indeed, 'respect and care for parents and the aged' has long been a norm and obligation of adult children in the Korean culture (Sung 1995). The customary expression has been for older parents to live with the eldest son, his wife and children in three-generational households, and for all to share in the work of a collective economic unit – usually an agricultural small holding or, in towns, a domestic manufactory or shop. In well-functioning and harmonious households, all members mutually created and received its material and emotional support, for all contributed to the domestic, semi-subsistence and substantially non-cash economy, which was organised around the senior couple so long as they were healthy, active and competent.

While the primary rationale for the arrangement was rooted in agricultural production, if an older parent (or indeed other member) became physically or mentally frail, support was supplemented with care, even in its intensive forms. The responsibility to remain in the

parental household, and to take care of them when old, was not however imposed equally on all children. The normal expectation was that the eldest son would live with the parents, while other sons and daughters had less responsibility. Nonetheless, the norms of filial piety affected all children, for the complement of the instrumental responsibility was that the eldest son and his wife were granted more privileges than the siblings, particularly with reference to education and the inheritance of property. Eldest sons who cared for older parents were favoured through 'a silent promise' or 'taken-for-granted' contract.

In contemporary society, however, the traditional familial values and customs have significantly weakened. As a demonstration, the belief that the first son has to take the main responsibility to support and care for his elderly parents is fading. Successive surveys have found that in 1979 30.6 per cent of South Koreans aged 14 years and over believed that the first son should take the prime responsibility, but only 19.6 per cent did so in 1996 (Ministry of Finance 1992, 1996). The reasons for the decline include the spread of primary, secondary and higher education, its impacts on material and occupational aspirations, and increased women's participation in employment and non-family social activities (Chen 1986; Ingersoll-Dayton and Saengtienchai 1999; Lang 1946; Palmore and Maeda 1985; Silberman 1962; Chi 1988; Sung 1998). Participation in employment among married women increased from 37 per cent in 1970 to 50 per cent in 1997 (Choi 2001).

The traditional multi-generational and extended family household production unit provided a context for mutual support and inter-generational care which was underpinned by reciprocity and reinforced and legitimated by filial piety. By contrast, in a modern or post-modern economy the commodification of labour is predominant and domestic forms of production are rare. The pursuit of employment and production becomes competitive rather than symbiotic with the care, support and respect for weak and sick household members (including frail parents). It encourages young people to migrate to the cities, where millions experience insecure employment, low income and residence in the rudimentary dwellings of 'substandard settlements' (Ha 2001; Ha and Lee 2001). During the 1997 to 1999 economic crisis, the levels of poverty and eviction in these settlements climbed substantially, and private income transfers to older parents fell sharply (Kwon 2001). Urbanisation has reinforced this, for neither shanty towns nor high-rise city apartments are as accommodating of three-generational households as rural houses (Choi 1999).

TABLE 2. Family household types: South Korea 1960–1995 (per cent)

Year	1960	1970	1980	1990	1995
1 generation	5.3	6.8	8.8	12.0	15.3
2 generation	65.4	70.0	73.1	74.1	73.3
3 or more generations	29.3	23.2	18.1	14.0	11.4

*Note:* The tabulated households exclude one-person or non-kin households, 14.8 per cent of all households in 1995.

*Sources:* For 1960–1990: Korea National Statistical Office (1997). For 1995: Kwon *et al.* (1995).

TABLE 3. Living arrangements of older people: South Korea, 1997 (per cent)

Co-resident with children <sup>1</sup>	Living alone	Living with spouse only	Other <sup>2</sup>	Total
56.2	19.4	22.9	1.5	100.0

*Note:* The sample size was 1,888 people aged 65 years and over.

<sup>1</sup> Own or child's home.

<sup>2</sup> Co-resident with a relative or friend or in a residential care or sheltered home.

*Source:* KIHASA (1997).

The decline in multi-generational living arrangements in South Korea has been exceptionally rapid (Table 2):

The proportion of older people (65 years or more) who lived with their children dropped from 77 per cent in 1984 to 50 per cent in 1994. In Japan, the corresponding percentages decreased from 73 in 1975 to 60 in 1989, and in Taiwan from 72 in 1989 to 66 in 1995. (Kim and Rhee 1999: 95; Kim 1998: Table 1.1)

The complement is that the proportion of older people who live alone has rapidly increased, from 4.3 per cent in 1981, to 7.7 per cent in 1988 (Korean Gallup 1990), and to 19.4 per cent in 1997 (Table 3). Won and Lee (1999) have shown an inverse association between income or educational level and the likelihood of an older parent living with married children. For many decades the succession of birth cohorts has led to a rising proportion of the middle-aged having received secondary and higher education; the implication is that in the same way the residential independence of older people will become more prevalent.

Personal and political expressions of modernisation in South Korea have included heightened demands for human rights, freedom and justice. Since the fall of the military dictatorship in 1993, the country has been a democracy (Oh 1999). Women have demanded and been given more opportunities for higher education and they have sought

equal rights with men. Consequently, women's status has much improved, and their participation in the economy and social institutions beyond the household has greatly increased. Traditionally, house-keeping was regarded as defining women's role and most senior daughters-in-law were expected to care for disabled older people. Korean education and socialisation traditionally emphasised humanitarian and communal values, but now the educational curricula and value systems have been westernised, and individual achievement and 'actualisation' is widely accepted as the most appropriate guiding principle for individual behaviour and social life. In modern society, women with higher educational qualifications are less likely to 'sacrifice' themselves to become unpaid informal carers. One clear consequence is that in the current cohort of young adults, the majority of women do not want to marry men who are eldest sons – to avoid the traditional role. Paradoxically the rapid decline of fertility has meant that a rising and now high proportion of all sons are only and eldest sons. Modernisation has therefore reduced the opportunities for women to marry second and third sons: a rising proportion of daughters-in-law would have had to become 'main carers' if traditional household arrangements continued. Even among the wives of eldest sons, participation in paid employment and non-household activities has swiftly increased, reducing the availability of informal care for disabled and frail older people.

A decline in the population's willingness to care for frail older parents is inferred in many countries from the decline in multi-generational co-residence: a widespread over-interpretation. Actual changes in the emotional and instrumental relationships between parents and their adult children will undoubtedly have changed in intricate ways, but it is presumptuous to assume that all weaken the emotional or instrumental interactions between parents and children (Choi 2000). Just as successive cohorts of children have received more education and had the prospect of different, less physically arduous and more intellectually demanding occupations, so older parents' life experiences and expectations of their children will have altered. As everywhere, rising affluence, increased car ownership and spreading telecommunications, have increased the ability of the members of one generation both to keep in close touch with and to provide practical support for another.

Vivid accounts of new forms of mutuality and reciprocal support have been produced from the studies of the child-sponsored migration of South Korean older people to the United States, particularly Los Angeles (Lubben 1999; Lubben and Lee 2001). To make rapid

TABLE 4. *Newspaper reports of elderly abuse in South Korea, January to June 1997*

20 January	An elderly woman with dementia was trapped in a garage by her child and then died.
24 February	An old person with dementia committed suicide by throwing herself from the top floor of the house.
6 March	An elderly person with dementia was pushed into a wall by her son and died.
6 March	Several violent fights took place among five sons about whose duty it was to care for their elderly mother with dementia.
6 March	A woman with dementia went to the toilet and had a fall. Her annoyed son assaulted her and she died from her injuries.
13 March	A son who was depressed by his father with dementia committed suicide with his father.
22 March	An old person with dementia was assaulted and verbally abused.
23 March	An elderly woman was left in a house fire and died.
18 April	A husband who was depressed by his wife's dementia committed suicide with her.
24 April	An older person with dementia who had been missing for seven months was found dead in a valley.
1 May	A son who was angered by a conflict between his elderly mother and his wife abandoned the mother by a riverside.
16 May	An older person with dementia who had been missing for several months was found in the mountains.
16 May	An older person with dementia was abandoned in a shelter.
10 June	Three children refused to take care of their older mother with dementia. A son, annoyed by the conflict between his wife and her mother, put the mother in a tent on a river bank and gave her a few cooking instruments. She was found by a policeman.

Source: *Joonang-Ilbo* (Seoul daily newspaper) 1997.

material progress, both husband and wife in many recently arrived Korean migrant couples wish to work full-time, but professional child-care is very expensive. Commonly also, the parents in South Korea are impoverished and many feel deeply the absence of their child and grandchildren. The resolution is for the child to finance the parents' migration to Los Angeles, which in Lubben's sample of 223 occurred at an average age of 62 years, after which they provide child day care. A remarkable result among more than a few multi-generational migrant households is that the parents see their sons less often than those who, although in Los Angeles, live in a separate household. The finding demonstrates well the simplicity of equating co-residence with 'closeness' and 'care', and that innovations in constructive familial mutuality are ubiquitous but little understood.

There is nonetheless growing research evidence of 'carer-strain' in South Korea (Chung *et al.* 1998; Youn *et al.* 1999), and increasing media coverage of the physical abuse and occasional abandonment of frail older parents (Table 4). It is not clear whether the rising trends are

of the events or their reports: it may be, for example, that in the past the consensual norm of filial piety suppressed comparable reports in purposeful or unconscious ways.

Whether or not the prevalence of neglect and abuse has increased, the changed household arrangements and increasing expectation that a sick older parent should receive high quality medical and nursing care has increased the need and demand for formal domiciliary and residential health and social services. If this representation is correct, the task facing the South Korean government is twofold. It is to plan and manage the rapid installation of the health and welfare services that are increasingly demanded by an affluent, westernised population; and to respond to the special disadvantages that are widespread in the current cohort of older people and which are likely to continue for several decades.

### **Health care expectations and provision**

In Korea's pre-modern society, health care was the responsibility of the individual and the family, not of society or the state. It was customary that, aside from self-care, the family, the clan, the villagers and the community looked after the sick. Those principles have been substantially abandoned, and health care has become a responsibility of the state through the introduction of national health insurance and large investments in medical facilities and training. The number of hospitals and clinics trebled between 1975 and 1998, while the number of licensed doctors increased from 16,800 to 65,431. By 2000, total government expenditure on health and social welfare had reached 4,257 trillion won (US \$3.94 billion), 5.2 per cent of its total spending ([www.korea.net](http://www.korea.net), see Health and Medical Services). The South Korean government in 1977 initiated the development of universal access to health care with three founding principles: graduated compulsory coverage; contributions based on individual income; and the level of benefit to be independent of individual contributions (Son 1998a). It took 12 years, through measures that cascaded from large urban employers to own-account agriculturalists, to achieve universal coverage (Table 5). The scheme is divided into *Medical Aid* for people whose incomes fall below a poverty standard (about 4.3 per cent of the population in 1995), and *Medical Insurance* for the general population with variant schemes for the employed and self-employed. Coverage is not open-ended but has recently been extended. The maximum covered period of hospitalisation was 270 days in 1997, but has

TABLE 5. *Key steps in the development of universal health insurance in South Korea*

1977	Insurance compulsory for firms with more than 500 employees
1977	Government programme for low-income individuals established (Medical Aid)
1979	Insurance compulsory for government employees and private school teachers
1979	Insurance compulsory for firms with more than 300 employees
1981	Insurance compulsory for firms with more than 100 employees
1981	Three pilot schemes established for self-employed
1982	Three additional pilot schemes for self-employed started
1982	Insurance compulsory for firms with more than 16 employees
1988	Insurance compulsory for the rural self-employed
1989	Insurance compulsory for firms with more than 5 employees
1989	Insurance compulsory for the urban self-employed

Source: MOHW (1996).

TABLE 6. *Expenditure on health care in South Korea, 1985–96*

Year	Total Billion KRW	Services for older people	
		Billion KRW	Per cent of total
1985	583	28	4.7
1990	2,220	239	10.8
1996	7,424	976	13.1

Note: In August 2001, the exchange rate was one USA dollar to 1280 KRW. Billion = 1,000,000,000

Source: MCIC, 1985, 1990, 1996.

subsequently been increased incrementally to one year in 2000 (MOHW 2001).

Since the inception of *Medical Aid*, the utilisation of health care has immensely increased, by 12.7 times or 26 per cent a year between 1985 and 1996, while the patients' contributions to the costs have fallen. There has been even faster growth of expenditure on services to older people: by 35.5 times or 38 per cent each year (Table 6). The increased utilisation has been encouraged by the development of the mass media and its increasing coverage of health issues, therapies and the quality of medical treatment. It has encouraged an ever-greater understanding of disease and burgeoning demands for new treatments and care services. As in all countries, the awareness of health factors is positively correlated with the level of education, and so there is a lag among older people. However, as the proportion of older people educated beyond high school (14.9 per cent in 2000) is expected to reach 27.0 per cent in 2010 and 44.4 per cent in 2020, aspirations among this age group for

good health and functioning are likely to grow quickly (Chung and Oh 2000).

### **Health and social services**

Health care in South Korea is delivered predominantly by independent medical practitioners and private sector organisations which operate more than 91 per cent of all hospitals and clinics and employ 89 per cent of all physicians (Ministry of Health and Welfare 2000a). The private hospitals and clinics are mainly in urban areas, are largely unregulated, and operate in a competitive market. Their activity is heavily underwritten through the state health insurance schemes and the government's finance of medical, paramedical and nursing education and training. While the private market approach has raised the volume and quality of services, the level and growth rate of government health care spending have been problematic for successive South Korean administrations. The government 'has recently taken some bold [reforming] steps ... such as separating the prescription and sale of drugs and unifying the various health insurance systems into a nationwide scheme' (OECD 2001: 15).

Table 7 presents the current structure of health care services, which has four sectors: primary, secondary and tertiary care, and special hospitals. Among the diverse primary care institutions, the health centres, sub-centres and individual primary health posts are financed and managed by the government and provide health care for the needy and the weak. The nation-wide referral system allows patients to visit primary care facilities in their local area at will, from which when appropriate they are referred to specialists and hospitals. Since the universal national health insurance scheme was introduced in 1989, the demands on the primary care sector have rapidly increased.

Home health care was introduced in 1991 and operates from the primary care centres. In 1993 the *Association of Korean Registered Nurses* began to provide home health care from four hospitals. Additionally, the government provided a model hospital-based home health service from four tertiary hospitals during 1994–96, and it experimented with similar schemes from 45 secondary hospitals during 1997–99. The hospital-based home health services focus on the nursing care of patients who are discharged at an early stage from acute hospitals, while the home health services that operate from primary care centres focus on health promotion and disease prevention among low income groups.

TABLE 7. *Types of health care facilities*

Primary care	Secondary hospitals	Tertiary hospitals	Special hospitals
Health centre	District:	Regional:	Mental health
Health sub-centres	100–699 beds	700+ beds	Rehabilitation centres
Individual practitioners	Local: 30–99 beds		Cancer clinics
Clinics			Communicable disease clinics
Special clinics			

Source: MOHW (2000a).

The development of health and welfare services in Korea has had a long history of conflict between traditional herbalists and ‘western’ biomedical physicians (Cho 2000; Son 1998*b*), but otherwise replicates many features observed in other countries (Le Fanu 1999). There is an uneasy tension between universal and targeted provision. The former has been driven by the growing expectations and rising affluence of the population and the mounting political ‘leverage’ of health issues; the latter by moral, humanitarian and collective concerns for the welfare of the most deprived. Welfare programmes targeted on the most disadvantaged and lowest income groups began in 1984 with means-tested forms of income support, known in South Korea as ‘Livelihood Protection’. These extended into food or ‘nutritional supplement’ programmes which operated from the primary care centres and laid the foundation for the introduction in 1983 of the ‘elderly health examination service’. This provides free health examinations, health education, early diagnosis and improved management of multiple chronic diseases among older people. Echoing the initial lack of enthusiasm among British general medical practitioners for the annual 75 plus years health check, the implementation of the scheme made a slow start. The quality of this service has subsequently much improved but, due to budget constraints, access remains limited to those who are eligible for Livelihood Protection. Services are also heavily concentrated in urban areas. Yoo *et al.* (1998) have shown that older people in rural areas have significantly more health problems than city dwellers even after all other variables are controlled, and they attribute the differential to the lack of health care services outside the cities.

Home care (or personal social services) was introduced in 1987 and expanded greatly from 1995 (MOHW 2000*b*). It supports those who have difficulties with the activities of daily living (ADLs) and instrumental ADLs through physical or psychological disabilities. Older people who are registered in the Livelihood Protection scheme

are eligible for free home care, while those recognised as in poverty are charged on a direct-cost payment basis. Other older people can only access fee-for-service home care. As the majority of home care clients are eligible for Livelihood Protection, it is apparent that most of those in need do not wish to pay for home care services or find that they do not provide value-for-money.

Day care centres for old people provide bathing facilities, rehabilitation, social activities, and meals to those who are mentally or physically disabled and whose family are not available to care for them during the day. The number has been increasing and reached 37 in 1999 (MOHW 2000*b*). Like other services for older people, access to this service is confined to a small minority of the poor. Respite care aims to relieve family carers, for example, by enabling them to take a vacation from the long-term care of a disabled older person. This service provides assistance with ADLs, rehabilitation and meals. The duration is limited to 45 days, and not more than three months' care is provided to an individual during a year. The providing centres increased from 15 in 1997 to 19 in 1999, but remain too few, and access is again limited to poor older people.

### **Residential and nursing home care**

As in other countries, one of the most challenging areas for health policy in South Korea is to develop a national strategy for the long-term care of frail older people. Specialist care services for older frail people are categorised into the elderly health examination service, dementia services, and long-term care. Continued adherence to the principle that the family supports and cares for older parents has hindered the development of residential care. The main types are residential homes, nursing homes, specialised hospitals for old people, and municipal and provincial dementia hospitals. As in northern European countries, residential homes are for older people who suffer from disabling or multiple disorders and need assistance with functional limitations, while nursing homes are mainly for those who are suffering from dementia, paralysis or severe functional limitations and need nursing care. There is little evidence on how well this distinction is maintained, *i.e.* whether there are good assessment and admission procedures or considerable mis-matching of needs with placements. Specialised hospitals are for people who have serious (and often multiple) chronic diseases and need continuing medical treatment and

relatively intensive nursing care. Access to free institutional care is limited to the poorest older people.

There are too few residential places for physically and mentally impaired old people, and a substantial proportion of the available places are luxurious and serve the rich. Among those aged 65 years and over, only 0.3 per cent are resident in institutions, compared to 6.0 per cent in Japan, 5.7 per cent in the United States and 5.1 per cent in the United Kingdom (OECD 1998). Currently, most Western countries are prioritising the development of home-based services rather than residential services, to reduce the aggregate cost of 'elderly care' and to improve the quality of the users' lives. The experience of Western countries warns against the dangers of developing excessive residential care but, at this time, there is undoubtedly a pressing need to increase provision.

By a revision of the Elderly Welfare Act in 1993, the establishment of independent homes in a competitive market for residential care was permitted to encourage private sector investment. Various individuals and companies expressed interest in establishing residential homes, but the legislation forbids the sale of a care home and this has retarded investment. Only non-profit organisations, such as religious organisations and charities, and a large commercial company that seeks to improve its image, are expected to become involved in the expansion of provision. To encourage their involvement, during the period 1993 to 2000, the government made US \$8.7 million per annum available as loan finance to the private sector.

Until recently, most Koreans accepted a responsibility to care for a demented parent fatalistically, and as an expression of their familial responsibility. They were unlikely to send the parent to a mental hospital – an eventuality which, since 1989, has been covered by the national health insurance (Sung 1996). Partly for this reason, mental health services for older people did not initially develop strongly. Recently, however, the population's understanding of dementia, and its attitude to the care of an older person with dementia, have changed, and the demand for services has greatly increased. The adoption of both Western models of health care and of a rationalist view of mental illnesses have produced a spreading expectation that the afflicted patients will be treated and cared for by professional medicine. Care services for demented people were first introduced in 1997 with the aim of improving the quality of patients' lives. Public health centres operate this service, which involves diagnosis, registration, care assessment and care planning. In addition, counsellors provide information and advice to informal care-givers, and advocate for their support. The public

health centres also provide home health services to the registered patients.

The Ministry of Health and Welfare (2000*b*) has recently published standards and regulations for residential and nursing homes, but most are unambitious. As one example, nursing homes will be required to employ one nurse per 50 residents, very low in comparison to the standards of other countries. Moreover, nursing standards are not specified at all. As found in other countries, regular inspection of the homes is essential to secure the quality of older people's lives, but this has not yet been introduced. The pressing tasks for the government and the country are therefore to increase the numbers of residential care places, to set higher standards of care, and to establish effective quality assurance through regulation and inspection.

While long-term care services for older people in South Korea are less developed than in Western countries they are now a government priority, and both community nursing and residential care services are being developed (Shin 1998). Although domiciliary services are available to patients of all ages, the largest patient group consists of older people, including those with terminal conditions such as cancer, those recuperating from surgery, and those with functional disabilities. The majority of South Koreans are largely unaware of the capacities of the community-based services, and the nurse-provided home health services do not meet the public's expectations: the public still prefer hospital-based physician services to which they have been accustomed. Because of the limitations in the ability of home health services to meet the complex health care needs of old people, and because the system makes charges and the quality of its services is not uniformly high, only a small number of older people are supported by the home health services.

### **Conclusion**

The changed social circumstances of older people in terms of support and care have not been caused simply by population ageing, but also by interacting economic, social and attitudinal transformations. The negative consequences are commonly described as impacting on older people, but it would be more accurate to say that they have particularly affected a defined birth group or, in individual families, the specific generations whose expectations for their living situation and support in old age have been denied and disappointed. For them, the 'silent promise' has been broken: later generations and cohorts will not

acquire the same expectations and may have more substantial assets and welfare entitlements. The severest impacts are on a 'transitional generation' of older people, most of whom have attained or will attain old age during the two or three decades each side of the millennium, whose eldest (or any) sons have broken the sequence anticipated by the inter-generational understanding. The analogous changes in Western Europe were spread over up to five generations and, reflecting the longer phasing of occupational and educational change, were more gradual. In South Korea, however, the transformation has been concentrated into one or two generations of the nation's older people.

The development of health and welfare services in South Korea has to date been strongly influenced by the structure and divisions among the welfare professions and medical specialties. The dominant influence of physicians has contributed to a low priority for 'care' rather than 'cure', and for the rehabilitation and the management of chronic conditions. The dominance is even greater than in southern European countries and may derive from the century-long conflict between traditional and Western bio-medicine. Meanwhile, the influence remains weak of other health professions such as nurses, physiotherapists, and occupational therapists. Even in the development of care services for disabled older people, the focus has been on the expansion of acute medical services, while community care and rehabilitation, long-term care services and personal social services, have been little developed. Nor yet have there been substantial initiatives to improve the co-ordination and joint working of different services.

Although care services for frail and sick older people have a relatively short history in South Korea compared to Western countries, they have rapidly developed since the 1960s, but still have many limitations. Most are available only to those minorities of older people who are either eligible for 'Livelihood Protection' and have very low incomes or are very rich. The needs of the majority of frail older population are not being met. As Kwon says of the underlying logic of the country's social policy, 'the vulnerable population has been left out rather than protected, and the workings of the system are divisive rather than an enhancement of the solidarity of society' (1997: 481). As well as the quantitative shortfalls, there are concerns about the quality of many older people's services. A priority now is to set and implement minimum standards of care and stronger systems of regulation and inspection.

Other limitations of the current health and social care system include widespread public ignorance and misunderstanding about care

services, and severe shortages of staff in many grades. Most care services depend heavily on volunteer staff. There are, nevertheless, strengths in South Korea's care services for older people: first, although the private hospital and clinic functions are unregulated (Shin 1998), the highly competitive market in which they operate has had a positive influence on the quality of acute medical services (Yang 1996). Secondly, while economic development, the dominant concern of successive governments from the 1960s to the early 1990s, has created barriers to the development of care services for older people, the current administration has shown a concern for and commitment to health and welfare issues, including those particular to older people. While public expenditure and fiscal concerns may have been paramount, the government is now actively developing a long-term care policy which should result in increased and improved residential and nursing home care provision. As even the OECD acknowledges (while strenuously advising the government 'to limit the impact of ageing on expenditures'), 'the traditional pattern of elderly care will need to be supplemented by a larger government role' (OECD 2001: 15).

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Accepted 9 July 2001

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