# Towards the development of care management in community care for elderly people in Korea

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## Abstract

This study is concerned with the feasibility of several forms of care management in the development of community care for elderly people in Korea.

Chapter one introduces the background of community care in Korea in the light of demographic, socio-economic, and political realities. This chapter reviews the changing Korean society as a barometer to understand the scope, size, and speed of social needs, especially community care for elderly people, over the last few decades.

Chapter two explores various definitions, concepts, and theories of community, community care, and care management by building upon trends previously established in the research. This helps to identify the different models of care management and the pre-conditions necessary for the application of different models in Korea.

Chapter three explores what factors have affected the development of community care, and what community care has achieved for elderly people in the UK. Specially, care management in community care for elderly people in the UK is examined in detail.

Chapter four details the findings of field research on community care for elderly people in Korea. This covers the needs of elderly people and their carers, and the social worker's tasks and available resources. The potential for the use of care management based on the findings of field research is assessed.

Chapter five investigates whether the UK models of care management are suitable for Korean society, which interventions are useful for developing care management, and the strategies, and principles involved.

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## List of Abbreviations

| | |
|---|---|
| AOA | American Occupation Authorities |
| BASW | British Association of Social Workers |
| CSO | Central Statistics Office |
| DHSS | Department of Health and Social Security |
| DOH | Department of Health |
| ECC | Elderly people cared by community care |
| ECF | Elderly people cared by family member |
| EOC | Equal Opportunity Commission |
| EWA | Elderly Welfare Act |
| GDP | Gross Domestic Product |
| HWC | Health and Welfare Centre |
| HWCP | Health and Welfare Centre Project |
| KIHSA | Korea Institute for Health and Social Affairs |
| MHARK | Ministry of Home Affairs, Rep. of Korea |
| MHSARK | Ministry of Health & Social Affairs, Rep. of Korea |
| MHWRK | Ministry of Health and Welfare, Rep. of Korea |
| MJRK | Ministry of Justice, Rep. of Korea |
| MLRK | Ministry of Labour, Rep. of Korea |
| NASW | National Association of Social Work |
| NHS | National Health Service |
| NSORK | National Statistics Office, Rep. of Korea |
| OECD | Organisation for Economic Cooperation & Development |
| PSSRU | Personal Social Service Research Unit |

# INTRODUCTION

## OBJECTIVES OF THE STUDY

This thesis examines various aspects of the use of the care management service model. In doing so contextual sociological, ideological and political questions relevant to this enquiry are addressed(see background of the study). In developed countries such as the UK and the USA, there have been strong moves away from institutional to community based care for many clients groups - including children and young people. Korea is one of several advanced-developing countries (eg.Hong Kong is another) progressing to community care from traditional informal care by families. This is explained partly by the trend towards smaller nuclear families in Korea. An advanced-developing country such as Korea is seeking to move to a system of community care for older people from a very different starting point than is the case with a developed country such as Britain. Nevertheless, policy is changing in the same direction as in the UK, making it appropriate to explore the potential for introducing a culturally relevant form of care management. Specifically, this study aims to:

1. Examine why and how care management is being used with community care for elderly people in the UK, and with what effects;

2. Identify the different models of care management and the pre-conditions needed for the application of the different models in the chosen field of study;

3. Describe and assess the current state of community care for elderly people in Korea;

4. Assess the potential for the use of care management services based on identification of the needs of a sample of elderly people and their carers; and a study of the social care systems in the project areas.

## KOREA

The Korean peninsula is located in the Northeast Asia region. It lies between 124 and 131 E. and between 33 and 45 N. The area of Korea is 222,324 sq.km, with a population of over 70 millions. On the other hand, South Korea(the republic of Korea) is around 98,000sq.km with a total population of approximately 43m.

Although S. Korea itself is 53 years old, the history of the Korean peninsula stretches back over five thousand years. The division of the peninsula in 1945 into two nations that had been unified since the seventh century AD, is symptomatic of Korea's history as a whole.

S. Korea rapid economic development over the past four decades has given its people a strong sense of national pride. It has already assumed a leading role among the newly industrializing nations, and is close to achieving its dream of advanced nation status(see background of the study).

The values installed over the centuries through the influence of Confucianism remain intact - the importance of the family, respect for elderly people, and the desire for education. S. Koreans have maintained their artistic and cultural identify, which remains distinct from that of neighbouring China and Japan, for example their own language.

In traditional Korean society, care for elderly people was the responsibility of the children, specifically the eldest son. Although the family remains the principal source of

support for elderly people, increasing life expectancy and the trend towards the nuclear family have raised concerns about long-term care for elderly people(see Chapter one). The government provides support for elderly people who need care at home and considered 'economically incapable'.
As of 1995, the elderly(65+) population was 2,543,000. The number of elderly people receiving community care was 307,401, about 0.12% of the total elderly population. Nurses(2,791) in health centers(238), plus 4,068 nurses(with first and second degree) in health subcenters(1,327) and primary health care posts(2,039) were employed by the government in Korea in 1995. The number of social workers employed by the local governments was 519 in order to provide community care for 307,401 persons, including 99,982 elderly people households in the whole country in 1995. There were 266 general hospitals, 398 hospitals, 14,343 clinics, 69 oriental medical hospitals and 5,928 clinics, and 238 health centers, 1,327 health subcenter, and 2,039 primary health care post in Korea in 1995(MHWRK,1996).

Table 0-1: Characteristics of S. Korea(1995)

| |
|---|
| * Location: Northeast Asia. |
| * Total population: 43.39m(65+:2,543,000). |
| * Area: 98,000 sq.km. |
| * N. of county: 137. |
| * N. of Health centres(238), Health subcenters(1,327) & Primary health care posts(2,039). |
| * N. of social workers employed by the government:519. |
| * N. people receiving community care:307,401. |
| * N. of elderly people households receiving C.C.:99,982. |
| * N of total households receiving C.C: 175,542. |

Source: MHWRK(1996), Yearbook of Health and Welfare Statistics, Vol.42, Seoul, MHWRK.
Note: N.; number, C.C.; community care

# BACKGROUND OF THE STUDY

## Subject for the study

The UK and Korea(South Korea) are not the only societies internationally now facing serious dilemmas because of the increasing proportion of elderly people in their populations.

Table 0-2: The proportion of elderly people(65+): UK, Japan, Australia, Canada, USA, and Korea (%)

| | UK | Korea | Japan | Australia | Canada | USA |
|---|---|---|---|---|---|---|
| 1980 | 15.0 | 3.9 | 9.1 | 12.0 | 9.5 | 11.4 |
| 1995 | 15.5 | 5.7 | 14.1 | 11.3 | 12.4 | 12.9 |
| 2000 | 16.0 | 7.0 | 17.0 | 13.0 | 13.7 | 13.6 |
| 2020 | 17.5 | 13.0 | 25.0 | 17.5 | 20.0 | 17.5 |

Source: OECD,1994; Goodman & Peng,1995,p.54

Health and social services particularly are concerned about escalating costs of the ever increasing demand for treatment and care by the over 65 age group. Therefore, for more than thirty years, community care for elderly people has been an influential concept, an evocative slogan which justified some of the best developments in long-term care in the UK and elsewhere(Davies & Challis,1986,p.1).

There are several considerable reasons why community care for elderly people has to be developed in Korea, and why and how the UK model of care management in community care may be applied for the development of community care for elderly people in Korea. Community care in Korea has emerged in response to the social change, social needs and problems created by industrialisation and the disintegration of traditional forms of support for elderly people. Three main

sources of pressure - the growth in the numbers of elderly people needing help, the changing nature of the family and shifting family system, and elderly people's preference - are the mirror images to develop community care for elderly people in Korea.

First, with the lengthening of average longevity - 69.0 in 1985, 72.9 in 1995 - the number of those who are advanced in age is growing larger in Korea. Elderly people over 65 years in Korea as of 1995 was 5.7% of total population census(MHWRK,1995,p.80). Compared with the UK, whose elderly people consist of about 15% of the whole population, the number of elderly people does not seem to be serious problem. However, the number of elderly people is expected to be around 7% in 2000, 13% in 2020(MHWRK,1995,p.80)(see table 0-1 & 0-2). The same processes that are producing an ageing demographic structure are also rapidly increasing the numbers of people who are frail and dependent because of their old age(Dallos & McLaughlin, 1993, p.136). In this regard, we should prepare appropriate measures to cope with further problems of caring for elderly people.

Second, the family system has shifted from extended to nuclear. Multi-generation households, more than three generations, numbered 28.6% in 1960, 20.1% in 1975, 16.2% in 1985 (Palley,1992,p.788), and 12.5% in Korea in 1992 (Goodman & Peng,,1995,p.14). In addition to the recent decline in average family size, 5.2 in 1970, 4.5 in 1980, and 3.7 persons in 1990(NSORK,1993,p.262), there has been an increase in intergenerational friction and a decline in the status of the elderly as their formerly significant family roles are diminishing(Kim,1990; Palley & Usui,1995,p.243). Young couples increasingly prefer residential separation, although

most still accept responsibility for retired parents within their household(Koo,1984; Palley & Usui,1995,p.243). The nature of the family itself is changing, partly as a consequence of the ageing process. More people are living in single or in two person households. Separation, divorce, and remarriage have for large sections of the population complicated the traditional definitions of expectation and obligation between parents and children (Dallos & McLaughlin, 1993,p.135). The rate of elderly single households and two elderly people households was 5.2% of all households in 1989 (KIHSA, 1992,p.74), 8.7% in 1994 in Korea(Lee et al,1994, p.24).

The idea of women as providers for the care of elderly people may also be drawn upon. Women have more opportunity in paid work outside the home than had their mothers or grandmothers. The rate of women labour force participation, rising relatively rapidly, was 37.2% in 1965, 42.8% in 1980, 45.0% in 1988, 48.0% in 1993 in Korea (MLRK, 1993,p.15)(see the details in chapter one). Within the context, if these trends are maintained, we can pose the question, who supports and who are under obligation to care for elderly people in Korea in the future ?

Third, we have to recognize another dynamic of community care for elderly people in Korea. Elderly people's preferences, which affect the community care, have been changing quite rapidly. The evidence emerges from Rose & Shiratori's research(1986). Korean elderly people wanting to live with their family was 58% in 1983(p.69), 47.3% in 1994(Lee et al.,1994,p.67). Compared with 9% of the UK(Rose & Shiratori,1986,p.69), it is still a very high percentage. However, more Korean elderly people want to live

independently if they are economically supported and provided appropriate care services by their family or community. Improvements in income and housing conditions have allowed many more elderly people to live on their own and in their own home in community(Dallos & McLaughlin,1993,p.135). When it is difficult for elderly people to be supported by their own kin or kith, public assistance or welfare services by state or community must be provided. The recent statements by the Korean government concerning the impending problems of an ageing society seem to suggest a state-led strategy to anticipate and reserve welfare 'problems' well in advance (Goodman & Peng,1995,p.12). The Government also strengthens the health and social services for elderly people staying at home, by providing such things as allowances and home help services(MHWRK,1995,p.80). However, some problems in health and social services - the increasing complexity of the care system hindering accessibility for those requiring care, a differentiated and segmented care provision, service-led services, and the issue of responsibility for and continuity of care - must be recognized.

In the UK, effort for community care has been made since the 1950s in order to address the problems concerning the care of elderly people. Equally serious problems in existing service systems were identified as those formed in Korea. As a result, care management in the care of elderly people in the community was imported from North America at the end of the 1970s. Some promising prospects for care management in community care provision have been demonstrated in some community care schemes, such as the Kent ,the Gateshead, and the Darlington schemes. Challis et al.(1993) evaluated these schemes:

"In all of the studies there was a reduction in the use of institutional care facilities,...the quality of life of elderly people and their carers receiving these case management services improved significantly more than those receiving the usual services....achieved at no greater cost than existing services, indicating improved efficiency in care provision"(p.200).

However, the question is whether or to what extent the models of care management in community care for elderly people in the UK would be effective provision in community care for elderly people in Korea, which is an advanced-developing country. My question is supported by Midgley's statement (1984):

"Many social security schemes in developing countries today are ineffective because they are inherited or uncritically copied from the industrial countries. The replication of the innovation in other developing countries could be inappropriate"(p.209).

Some commentators posit certain preconditions necessary to introduce social services developed in industrialised countries to developing countries. In the next part of the study we discuss general preconditions to introduce care management in community care for Korean elderly people.

## Significance of the study

While it is true that Korea has made much progress economic condition over the last 30 years and Korean people today have higher living standards than they did less than a generation ago, economic development has not been accompanied by an attendant degree of social services development. The current state social welfare system in Korea consists of three components: i) Social insurance(health insurance, national pension, worker's compensation); ii) Public assistance

(livinghood protection, medical aid, veterans relief, disaster relief); iii) Social services(for the disabled, elderly people, children, women and people with learning disabilities). On the other hand, social policy in Korea increasingly encourages developing voluntary and private sectors. For example, if any institution or enterprise sets up facilities for social care, they could get tax reduction or exemption. However, the welfare service system in Korea is still in its developmental stage and its scope is being expanded gradually(see chapter one). A recent report of the Korean government is a useful starting point for introducing this study. Year One of the Welfare Era (Bokjiwonnyen) was introduced by the government in 1995. It means that Korean government will give sufficient attention to redefining the role and purpose of social service institutions in the new policy environment such as joining the OECD and launching local autonomous government. Korea may actively adopt various aspects of Western social service programmes, and reassemble and reconstitute them into its own systems according to its perspective on cultural, political, and social backgrounds. But it would be difficult to demonstrate that Korean welfare has followed or mimicked any particular Western pattern (Goodman & Peng,1995,p.3). However, the UK and Korea are selected for the study because of my own experience as well as because of its suitability to contribute to theoretical and practical policy development of community care programme for elderly people in Korea.

There are numerous studies in the areas of welfare services especially on the development of community care in Western countries. However, the welfare service programmes of the developing countries have generally not received scholarly

attention. Rimlinger(1971) mentioned the reason for this:

"The developing countries are in a special situation. They can borrow from a wide range of patterns of social protection that have proved successful in countries that industrialised earlier. The developing countries....their problem is one of choosing the most suitable pattern"(p.334).

Although some welfare service investigators in developing countries have borrowed established theoretical models from the corpus of Western social policy research to account for events in the developing countries, few of these models have been vigorously tested in the broader empirical field of developing countries(MacPherson & Midgley,1987,p.83). It is assumed that the development of welfare service programmes in developing countries basically follows in the steps of programme development in advanced industrial nations, and that their further development will constitute a replication of patterns currently evolving in the industrial countries (Kang,1992,pp.1-2).

Some writers claim that general preconditions must be met before the welfare service development process can be successfully initiated(Midgley,1995,p.79). For example, Cutright(1965) argued that:

"Actual activities of government in the social service field were strongly related to the complexity of social organization in economic, social, and political institutions"(p.548).

Another writer, Titmuss(1974,p.22), argued that:

"When we study social service systems in other countries,...they reflect the dominant cultural and political characteristics of societies. The perspective gained from comparative studies helps in the understanding of the social policies of their own country".

They refer to economic, political, and socio-cultural factors and social policy. Another statement which satisfactorily covers these elements was provided by Midgley(1984):

'different political, economic, and socio-cultural factors contributed to the development of welfare services in different countries'(p.124). It means that the theme of the development of welfare services in a society, firstly, is closely related to the level of industrialisation and the effect of industrialisation on other social institutions. Midgley (1995) argued that welfare service development cannot take place without a certain level of economic development, and economic development is meaningless unless it is accompanied by improvements in social welfare for the population as whole(p.23). It is implied that the formal welfare service schemes are not likely to develop for the functioning of the welfare system below a certain level of economic development in a country, although Gilbert pointed out that this level was very difficult to define(Midgley,1984,p.125). Cutright(1965) also notes that 'a scale of national welfare service programs is developed alongside and related to economic development'(p.537). However, in many parts of the world, a distorted development exists in societies where economic development has not been accompanied by concomitant level of social and welfare development(Midgley,1995,p.4). Korea is one of the distorted developmental countries.

Korea has had one of the fastest economic growth rates in the developing countries since the early 1960s. During the last three decades, the Korean economy has grown at an average rate of 8.9 percent per year. In 1993, a per capita GNP reached over US $ 7500 (MHWRK,1995,p.13). If the record of growth can be maintained, it is projected that by the early twenty-first century Korea will be as rich as the average of OECD countries is today. However, due to the recent economic crisis, it is expected that the Korean economic growth will be lower than the past periods. According to a Korean daily

newspaper, Korea Herald(05-07-98), the Korean Ministry of Finance and Economy forecasts that Korea's GDP growth rate will be about one per cent from the present to next year(see chapter one and conclusion - discussion on relationship between the recent economic crisis and welfare provisions in Korea).

Secondly, the historical context of politics and social policy for welfare services in Korea differs greatly from those of Western social policy approach because of various specific cultural and historical factors from the unique social situation in Korea. Historical experience, political ideologies, and dominant cultural values are embodied in individual lives, prescribing patterns of interactions between individual, family, community, and nation (Rho,1994, p.4). Korean political leaders have emphasized Confucian virtues regarding informal caregiving in the three-generation family as the basis of social policy(Palley, 1992,p.789). Midgley(1984) examined the relevance of social policy factors in the development of social security and concluded that:

"Many of the social service problems in developing countries are due to domestic factors such as administrative inefficiency and lack of determined and imaginative policy making"(p.158).

Lack of appropriate policy making has meant that many welfare service schemes are not relevant to the circumstances of developing countries and welfare service provisions are not related to changing social and economic reality( Midgley,1984, p.190). The political structure's emphasis on economic development makes it difficult to moderate any social stress factors through the development of a welfare service infrastructure. This political-economic orientation has resulted in a policy of minimal welfare services

(Palley,1992,p.788). However, the Korean government recently took on a policy designed to develop independent sectors which are to moderate any welfare demanding factors through the development of a mixed economy of welfare. It particularly offers welfare service programmes supporting community care for elderly people in Korea(see chapter one). Thirdly, the Korean cultural heritage, traditional values and beliefs, which are strikingly different from Western countries in many important ways, have a great impact on the development of welfare service institutions in Korea. Cultural factors expressed at the level of national ideology and political power are important for a proper understanding of the origins and present functions of modern welfare service institutions in developing countries(MacPherson & Midgley, 1987,p.138). The Korean culture has been and still is moulded by historic residues of the heritage in Korea such as the deep respect for the extended family, requiring reverence for 'elders and betters' in a family context. One of the characteristics of Korean society is the strong bond between members of one family. However, Midgley(1984) said that:

"Some writers have commended the introduction of social security on the ground that social needs are no longer being met adequately through traditional welfare institutions such as the extended family"(p.1).

Others have placed more emphasis on removing the structure of the traditional culture which, they believe, impedes the progress of welfare service development (Midgley,1995,p.79) As mentioned above, different political, economic, and socio-cultural factors have contributed to the development of welfare service programmes in different countries. Therefore, It can be said that the significance of this study is two-

fold. First, the study of the development of care management in community care can provide opportunities to look at the extent of the applicability of the UK model of care management to the Korean society. Second, this study can help to test how care management may be developed in the transition of family care from community care in the care of elderly people in Korea. More specifically, this study is concerned not only with the why but also the what and the how of care management(see chapters four & five). Such an approach should not fail to take into consideration a wider coverage and structural context within care management. Chapter one introduces background of community care in Korea, such as demographic, socio-economic, and political contexts. This chapter reviews the social change in Korea, seen as a barometer to understand the scope, size and rate of change of social needs over the last few decades. Chapter two explors concepts, theories, and previous studies related to community, community care, and care management. This helps to understand the nature and the relationship between elderly people and community care, community care and care management. Chapter three explors how community care for elderly people operates, and what factors have been influencing the community care in the UK. The problems and the countermeasures to the problems in community care for elderly people are identified. We focus on exploring why and how care management for elderly people operates in the UK. Chapter four details the findings of elderly people's and carers' needs, and social workers' tasks in Korea. In chapter five, we ask what are the implications of the UK care management models, and what revision to apply to the UK care management models to community care for elderly people in

Korea. Some strategies and principles for the development of care management in community care for elderly people in Korea are discussed. In conclusion, some discussions in related to the hypothesis formulated are given.

## RATIONALE FOR THE RESEARCH

There is currently an enormous upsurge of interest in the possibility of promoting welfare provisions on the basis of economic growth and the improved quality of life in Korea. It is commonly argued that Korean welfare provisions are faced both by increased demand by service users and reluctant investment by the government with which to meet that demand. Such pressure is especially shown in the personal social service provisions for elderly people, which mainly stems from consequences of increasingly population structure, and changing attitudes to elderly people and family system(see chapter one). The possible solution to the pressure that demands a response would be to increase the welfare provisions and/or increase the efficiency through the development of a new service delivery mechanism to secure more output. However, despite increased interest in seeking ways to provide better services, there are formidable problems to be faced by the most common promotion practice (Gibbs,1995,p.74). With promotion of community care for elderly people in Korea since 1980s, the new service mechanisms have been implemented to care for elderly people in a community(see chapter four) such as home help service in the Community Welfare Centres, joint collaboration working between health and social services in the Health and Welfare Centres. The evaluation of these service provisions have

shown a positive perspective on new service mechanisms. However, some issues have been tested and from the results we can expect to spell out the ending of certain problems. A central problem at system levels over these service mechanisms has been shown as the slow progress of their implementation due to bureaucracy (Lee et al.,1995, p.21). It is not hard to imagine that public sector bureaucracies would not take readily to the implementation of new service provisions as a response to demand or needs felt by service users. According to Ferlie et al.(1989), 'it may be organisationally impossible or at least extremely difficult to implement if the obstacles to change in bureaucracies given that radical innovation are underestimated'(p.9). In addition to this, there are expected to be a number of conservative forces which make implementation of a new mechanism difficult within the UK experience: entrenched producer groups, an incremental budgetary procedure, the political preference for the construction of visible monuments, and a reluctance to take risk(Booth,1979,pp.148-149). On the other hand, in terms of issues at the clients' level, a welfare service is commonly identified with some accompanying stigma sense such as the perception that financial relief damages his/her reputation and undermines his/her dignity in Korean values(see chapter four). As Spicker(1984) argues, there are a number of reasons as follows: 'degrading treatment, loss of rights, dislike of charity, labelling, and selectivity'(p.56). Therefore, it is expected that any stigma sense involved in setting up welfare services is a barrier for the development of new service delivery mechanisms. This is especially true for a clients-led or in-depth needs assessment approach in Korea.

In order to assess the potential feasibility of a care management in community care for elderly people in Korea, there is need to study the present state of community care including the health and social care process and how extended elderly people's needs are currently met. This means that before implementing new and better services for elderly people in community care, it is essential to know about elderly people's needs and to understand some relevant factors. 'Needs' are operationally defined as the statement of substantial or potential difficulty with a specific daily living activity and receipt of help from other persons in this specific daily living activity. Recently, estimates of needs for assistance with daily living activities among elderly people have been used as one indicator of the needs/demands for community care(Tennstedt et al.,1994, p.915). However, little data have been reported regarding needs for elderly people in Korean literatures(see needs and community care for elderly people in Korea in chapter two). On the basis of the UK research, for example, by Arkley,J.E.(1964), Brockington. F. & Lempert, SM.(1966), and Challis, D. & Davies, B.(1986), a comparison of findings across the studies of needs for elderly people is hampered by different definitions of need, by researchers' examining disparate activities of daily living, and using different volumes of sample size. As Tennstedt et al.(1994) argue, research based on representative samples of elderly people, using cross-sectional data, allows only a limited examination of needs for long-term care assistance. Therefore, in order to estimate needs for formal long-term care service, longitudinal data mapping the pattern of needs over time would be more informative. However, this study overall is an

attempt to answer such questions: what is happening in community care for elderly people's needs in Korea; why are certain features happening; and how does this affect what help must be given to elderly people in community care? More specifically, the first step will be to study social service resources; the circumstances and characteristics related to the needs of recipients and non-recipients of community care in a community; and the characteristics of the community care system in project areas. The second task is to analyse as well as examine how to generate arguments about the feasibility of care management in Korea. The study requires accurate and appropriate collection of evidence in the most efficient way. Even if not all social scientists are happy with the survey as a method of social inquiry, the more accurate and comprehensive the survey, the better can be the evidence for the study. Considering the writer's situation, such as limited time and funds, large samples with wide coverage of areas cannot be used for the study.

## RESEARCH METHODOLOGY

### Innovations

Care management in community care for elderly people in Korea may be perceived by the population and organisations as an innovative provision, activity, or technique. Therefore, it is questioned how care management, as an innovative provision, should be implemented in Korean society(see strategies for the implementation of care management in chapter five). We can learn from Rothman et al.'s(1976) argument, when he concluded from his study of a number of

areas of diffuse innovative service provisions(eg. education, agricultural extension, medical sociology, public health service) that:

"Innovations that are amenable to trial on a partial basis will have a higher adoption rate than innovations that necessitate total adoption without an anticipatory trial"(p.23).

They apply partialisation in two ways: one is by observability, which is to see the innovation in action and witness its result, the other is trialability which is to employ a portion of an innovation before having to employ total innovation. The study also emphasises the importance of opinion leadership. Furthermore, in a similar argument by Zaltman et al.(1973), the more obvious the innovative service provision is, the more easy it is to be adopted. The more amenable to demonstration the innovative service provision is the more viable its advantage is, and thus the more easy it is to be adopted(p.39). However, we should not forget criticisms of innovative strategy. A major criticism made of innovative service provisions is that they remain marginal showcase programs, often on pilot money only. The extent to which innovatory activity is replicated so as to affect mainstream practice is clearly of interest from the point of view of agency efficiency. Therefore, the length of time an innovative scheme has been operating, the geographic coverage, and whether transition to post stage has been achieved are taken as key indicators(Davies & Ferlie,1988, p.283).

There have been, of course, many restrictions and hindrances to introducing innovative schemes in Korea. These restrictions operate at different levels. Some examples of unsuccessful innovative schemes in Korea are such as the project for the Settlement Area and the scheme for a

separation between pharmacy and medicine(the requirement of a doctor's prescription to buy a medicine). The reasons for these failed innovative schemes are identified: sociopolitical, professional and administrative, and economic obstacles(see table 0-3).

Table 0-3: Characteristics of (un)successful schemes in Korea

| | |
|---|---|
| Unsucce-ssful | * bureaucracy to constrain change<br>* restrictions on resources, eg.)financial allocation<br>* group egoism<br>* mismatch between needs and objectives of scheme |
| Success-ful | * well-trained & experienced staffs<br>* well-assessed needs of community members<br>* well-cooperation between staffs and the public<br>* incremental/stepping-stone process<br>* meet preconditions to implement |

Although there always exist impediments to the implementation of innovative schemes, a number of successful innovative schemes in Korea, such as the New Village Movement and the NHS, the Green Revolution, have typical legitimate and conventional embodiments within the normative consensus of the population and its elites. The new schemes, as Rothman et al.'s argument above show, have been adopted in an incremental or stepping-stone process through demonstration projects: success on a small scale with a limited group has been used as the basis for promoting a new idea, or having those spread across a wider population. Such schemes of selection criteria have concentrated on a particular area in both rural and urban settings. The main criteria in both rural and urban areas suggested by the focus and design of my research are a very modest affair, compared with other areas in Korea, for three reasons.

Firstly, like many countries, there are strong regional

variations and imbalances between rural and urban patterns both in the needs for the care of elderly people and available service resources.

Secondly, at the time of planning the research, elderly people in the research areas, both rural and urban, have been provided with community care services by the Health and Welfare Centre which cover a large geographical area. This makes it unusual as most community care schemes in Korea are run by public interest bodies(eg.religious groups) with small coverage of geographical areas.

Thirdly, this scheme, which is the state-run pilot project of community care, is represented as an example of an attempt to find a new way of caring for elderly people. More specifically, two geographical areas(Hongchen-Kun & Kwanak-Ku) have relatively well developed mixed economics of care which is one of preconditions to operate care management. They have well trained social workers who have a positive attitude and experience of innovative schemes; well defined statistics of clients, systems, and services; many visitors who are engaged in social work and opinion leadership for observation and who take an important role of diffusion of innovation; more elderly people's experiences and a friendly perception of the innovative scheme.

One more practical reason why we have chosen these two areas is that we know well about the two areas' environments(one rural & one urban). However, the specific environments in the research areas have frequently kept clients and staff in touch with other researchers. A major concern is that they would become tired of questionnaires or interviews and would answer the questions without careful thinking.

## The study areas

### *Characteristics of the rural research area (Hongchen-kun)*

Hongchen-kun, a mountainous and traditional agricultural area, is a county in the central part of Kangwon province, located in the north-east of the Korean peninsula. The county is composed of 10 districts covering 29.65 sq. Km where social workers(12) and home visiting nurses(37) are allocated with their area-based tasks for community care(see chapter four). The county has a population of approximately 78,000 in 19,927 households. There are 7,425 elderly people(65+) in the county. The number of elderly people receiving community care is about 0.5%(398) of the total elderly population of the county. The number of lone elderly households receiving community care is 223.There is (1995) one general hospital, 20 clinics, 5 oriental medical clinics, one health center, 8 health subcenters, and 18 primary health care posts within the county.

Table 0-4: Characteristics of Hongchen-kun(1995)

---

* Location: central part of Kwanwon province(noth-east Korean)
* Total population: 78,071
* Area: 29.65Km2
* N. of total household:19,927
* N. of district: 10
* N. of social worker:12
* N. of Home visiting nurse: 37
* N. of elderly people receiving community care: 0.5% of T.E.P. Total:398, 65+(81), 70+(209), 80+(108)
* N. of lone elderly people household receiving C.C:223

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Source: Lee et al.(1995), The first year evaluation report of the development of models for the Health and Welfare Center, Seoul, KIHSA,p.223.

Notes:T.E.P.; total elderly population, C.C.; community care

*Characteristics of the urban research area (Kwanak-ku)*

The county of Kwanak-ku, a typical metropolitan area, is situated to the south-west of Seoul, which is the central part of the Korean peninsula. The area has a population of 575,256 in 185,650 households. Social workers(22) and home visiting nurses(25) are dispatched into 27 districts to perform area-based tasks covering the health and social care services in community care in the whole of the county(see chapter four). There were 12,779 elderly people(65+) in 1995. The number of elderly people receiving community care was about 0.4 %(489) of the total elderly population. The number of lone elderly people households receiving community care was 232. There is one general hospital, 6 hospitals, 174 clinics, one health center, and 69 oriental hospitals (clinics) in 1995.

Table 0-5: Characteristics of Kwanak-ku(1995)

| |
|---|
| * Location: south-west of Seoul(Central part of Korean peninsula) |
| * Total population: 575,256 |
| * Area: 29.60Km2 |
| * N. of total household:185,650 |
| * N. of district:27 |
| * N. of social worker:22 |
| * N. of home visiting nurse: 25 |
| * N. of elderly people receiving community care: 0.4%(489) of T.E.P.; 65+(118), 70+(260), 80+(111) |
| * N. of lone elderly people household receiving C.C.:232 |

Source:(ibid),p.219
Notes: T.E.P.; total elderly population, C.C.; community care

## A community profile

A community profile is a practical guideline upon which to prepare the viable local plan which becomes the initial basis

for action(Glampson et al.,1975,p.1). The purpose of a community profile is, first, to gather information about the needs of a locality and potential for action and, second, to provide the basis for an analysis of a possible alternative course of action from which to choose priorities(Twelvetrees, 1991,p.23). This involves, firstly, gathering hard information. It is useful to know the size and age structure of the population and manpower of the service sector from a census at a community and national level. Therefore, it is essential for the present researcher to collect data from census, other local and national sources, and information on service provision in research areas. It would give some information about how research areas have specific demographical environments for predicting the future direction of needs in community care. Information about the local social and health service delivery structures and resources available including all statutory and non-statutory agencies(a mixed economy of care) is basic and crucial in analysing community needs and resources of community care within a community. For research purpose, understanding where there is likely to be a local resource of data in a particular agency is crucial for acquiring particular information. For instance, the district offices(*Up, Myeun, and/or Dong*)(eg. Physically disabled elderly people/severely leaerning disabled elderly people registered, and receiving benefits), the health centers*(Bogunso)*(eg.elderly people's admission to psychiatric hospital). Contact with these information sources usually produces not only a wealth of relevant hard data but also some information about how to implement care management in community care for elderly people in a community in Korea.

Secondly, gathering information from the worker's agency and clients is another information. Different social workers may have different views on resource needs and existing service provisions within the current state of community care for elderly people. In particular, they should be aware of appropriate data already available within the agencies(the Health and Welfare Center), either available elsewhere in the department/offices, or available in other parts of the local authority(*Kunchung*)(Glampson, 1975,p.65). Questions about the tasks undertaken, available resources, and attitudes to innovative schemes can identify the scale, nature, and accessibility of resources and provide significant alternatives or supplementary contributions.

It is important that we not only take this opportunity to identify the gap between resource needs for tasks to be done and actual resources available, but also strive to assess the feasibility of care management in Korea. It has been necessary to read relevant records and to discover whether the HWC keeps some hard data which would be of use. It has also been important to look at past reports containing proposals for the area. By doing this, we are developing a sense of the history of agencies/offices in relation to the area involved(Twelvetrees, 1991,p.25). We should be able to predict more accurately how an agency will react to our own proposals. We must know whether a certain approach has been tried and failed(for example, Hongchen-kun - a pilot project area for NHS). It is also important for a researcher to obtain views from a different range of people and levels, particularly from people who may be sceptical about community care for elderly people(Twelvetrees, 1991,p.25), for example the owner of a *yangnowon*(an institutional provision).

## The empirical research

The aim of empirical research is to identify the needs of a sample of elderly people in urban and rural environments in Korea; and assess the extent to which the system of formal social services may be adapted to better meet these needs through the introduction of suitable care management service models. Secondary data have mainly been used for chapters one, two, and three. The data presented in this study have been gathered primarily through books, periodicals, and government or government related organisations. Such analysis has been done quite rapidly and inexpensively. The key problem with secondary analysis is validity. When one researcher collects data for a given purpose, other researchers have no assurance that such data is appropriate for their research interests(Wagenaar et al.,1989,p.111). In chapters four and five, widely different kinds of data have been used - primary data and secondary data. The secondary data have been used as supplementary to the primary source. The primary materials used for the study comprise of a field survey. In some respects, the survey is quite flexible, and the use of standardized questions enhances reliability. However, standardization often results in overlooking other appropriate responses and may generate inflexibility in modifying questions. Any survey research is also weak on validity even when strong on reliability(Wagenaar et al.,1989,p.111).

### *Research design*

This study has not used an experimental design, but has used

a posttest-only comparison group design, which is one possible pre-experimental design. In this design, there is an experimental group and a comparison group, but each is measured only on a posttest; there is no pretest(we use the terms comparison group instead of control group in those cases in which randomization and experimental manipulation are not performed). One serious problem with this design is that individuals in the two groups might have differed initially with respect to the dependent variable measured. The internal validity of this design is weak; too many critical intrinsic and extrinsic variables are not controlled for(Nachmias & Nachmias, 1976,p.47).

However, the practical reasons we made the choice of a post-test comparison group design were time and cost considerations. Time restrictions forced the researcher to opt for the research design that could be performed in a reasonably short period of time. Also, the researcher's limited funds favored the selection of the research design that was not too expensive.

*Sample size, targets, and sampling*

Sample size is the most potent method of achieving estimates that are sufficiently precise and reliable for research or scientific inquiry(Henry,1990,p.117). Sampling variability decreases as the sample size increases. However, a larger sample size requires more expenditure for collecting data. The factors to be examined in the choice of sample size include: implication of the sample size and design for sub-population analysis; adjustments for ineligibles and non-response; expense of the design given the sample size; and

credibility(Henry,1990,p.118).

It is proposed to interview 20 elderly people who have been receiving community care services(ECC). A second sample is of 20 elderly people who have been supported by only informal care-givers, without community care services(ECF). There was a further sample of 20 carers who have been providing informal services to their elderly relatives in their homes. Also 20 social workers in the Health and Welfare Centre, will be interviewed(see Table 0-6).

Table 0-6: Sample size and targets

| | Urban | Rural | Total |
|---|---|---|---|
| ECC | 10 | 10 | 20 |
| ECF | 10 | 10 | 20 |
| Carer | 10 | 10 | 20 |
| Social worker | 10 | 10 | 20 |
| Total | 40 | 40 | 80 |

Notes: ECC; elderly people cared by community care
ECF; elderly people cared by family member

The samples are chosen from both rural and urban areas. The objectives require that the client sample should be chosen in such a way as to represent the range of services provided and to do so in such a way that their effects can be compared(see the previous discussion(p.20-21). We also require that the sample should represent as far as possible the full range of needs for daily life among the elderly people being assessed for research. The study has used random sampling.

*Producing data*

Focused in-depth interviewing has been undertaken with

elderly people concerning various points of their needs through semi-structured questionnaires. The interviewer has been able to prompt the informant for further information or to explain misunderstandings. There has been a limited number of the interviews done in a day, around 6 interviews for two interviewers(interview schedule in detail is given Appendix B). The interview has been more like a conversation, and all exchanges have been recorded. However, recording has made the interview more artificial and a less natural situation. For example, during the interview, interviewees have asked "anyway where are you from, county office or Government" ?. It has been very difficult to develop rapport with the informants. They have not put trust in the interviewer. Eventually the end, we have given up recording after a few interviews. In addition to this, interviews have been conducted with carers and social workers with structured questionnaires.

*Data analysis*

Data have been collected and entered into a computer and analysed by using SPSS PC+. We have employed frequency distribution which indicates the average performance of a group on a measure of some variables. Also Chi-square (Fisher's Exact test), the most commonly used inferential statistics method, which is used to establish whether there is a significant difference between samples, is used.

*The possible use of other research designs*

A study by Challis & Davies(1986) used an experimental design

for the evaluation of the new approach 'care management', which focused on interested in cost-effectiveness and the social care process of caring for elderly people in community. Two groups were founded by randomly allocating the chosen population to experimental and control groups. In such a design, extreme care is taken to ensure that every person in a target population has the same chance to be selected for an experimental or control group, by random processes. Therefore, in the long run, any systematic difference between groups will be averaged out(Goldberg & Connelly,1982; Challis & Davies,1986,p.18). Service providers may argue that the allocation of cases to service on a random basis is unethical and against principles of social justice. In an experimental scheme, a randomized design would mean that control cases might receive an improved service, thereby distorting the comparison. To detect the effect of a single treatment as well as the effects of a programme on the system of care, separate areas are investigated. An alternative approach to tackling these difficulties is the quasi-experimental design(Campbell & Stanly,1966; Challis et al.,1995,p.51). Challis et al.(1995) employed a quasi-experimental design to examine the relative effectiveness of the care management and health care of older people, compared with long-stay hospital care. The choice of design was determined by the administrative aspects of the project and by the need to study the project as a system through its effects on individual clients. However, a number of factors militated against a random allocation procedure(Goldberg & Connelly, 1982; ibid). The design is weaker on internal validity than is experimental deign(see research design).

*The questionnaires design*

Questionnaires(see Appendix A) were devised for the quantitative research. It takes approximately forty minutes to administer. The function of a question in a questionnaire is to elicit a particular communication. Therefore, it was required for us to do pilot interviewing. As far as this study is concerned, three domains of questionnaires based on PSSRU experiments(the Kent, the Gateshead, and the Darlington projects) in the University of Kent, *General Household Survey: people aged 65 and over*(OPCS,1991), and *General Household Survey: informal carer*(OPCS,1985) were used, constructed for carers, elderly people, and social workers. However, there was a small possibility for the respondents to misunderstand the terms used in the questionnaires. It is commonly agreed that the majority of the terms used in the welfare sector in Korea are translated from ones created by western academic society. For example, care management is called 'sarekwanrhee'. A brief resume of contents of the questionnaire is as follows:

**The questionnaire for elderly people**

* Sociodemographic factors
* Personal activities of daily living & instrumental activities of daily living.
* Physical & mental health
* Current service allocation and needs satisfaction
* Attitude to welfare services already received or to be received.

**The questionnaire for carers**

* Characteristics of carers.
* Activities
* Consequences of care-giving in carers' life
* Needs for coping and caring skills
* Attitudes to caring for elderly people

**The questionnaire for social workers**

* Background information
* The tasks undertaken
* Available resources
* Other system factors

# CHAPTER I

# THE CONTEXT OF COMMUNITY CARE IN KOREA

Most literature on the subject of community care offers rich accounts of its origin and development, but the work has been mostly applied to the Western societies of the last few decades. Moreover, the explanation and theoretical formulation offered by existing literature on community care mainly considers its origin and development as the combined effect of the internal economy, political philosophy, and demographic forces. As argued by Higgins:

"Many interrelated economic, political and ideological factors affect both the wider context of welfare and the specific formulation and implementation of community care policies for elderly people"(Higgins, 1981;Tester, 1996,p.13)

The available literature does tell us exactly how and why these factors influence the development of community care. However, it remains unclear as to what the interaction between these factors is and just how much they influence the final outcome of community care.

In Korea, community care for elderly people has been undergoing both qualitative and quantitative changes in the past two decades(see chapter four). We need to examine the major factors influencing the evolution and development in the light of Western experiences. This chapter is largely concerned with understanding the relationship and interaction between the following major factors: demographic, socioeconomic, and political contexts, all of which are possibly entailed in the development and emergence of

community care. In the study, the emergence and development of community care are viewed as dependent variables, and we ask what environmental forces influence the content of community care in Korea.

## DEMOGRAPHIC CONTEXTS

The increase in the number of elderly people was predicted a long time ago, but the reaction to the change has been relatively recent in Korea. This is due, first of all, to the government's population policy which has given priority to birth control. Secondly, it has been recognised for policy-makers that social problems stemming from elderly demography changes can be solved through Confucian doctrine-oriented family policies(Yoon,1995,p.7). It is questioned what and how much these two policies have been incorporated into the evolution and development of community care for elderly people. In sections of this chapter, firstly the population size in reference to population policy is presented. Secondly, the population structure, which is one of the important demographic factors for the development of community care for elderly people, is analysed.

### Population policy and size

In Korea an extremely high birth rate had been maintained until the adoption of the population control policy in 1961(Chang,1993,p.59). At the time of the 1949 census, the total population of Korea was around 20 million and the population increase rate was 49 in 1,000 persons. On the other hand, in the 1990 census, the population reached around

42 millions and the population increase rate was below 10 in 1,000 persons. As we can see table 1-1, the rate of decline in the population has increased since 1960 mainly due to the successful accomplishment of the new population policy (Yoon,1995, p.10).

Table 1-1: Total population and vital statistics 1949-1995 in Korea, Per 1,000 persons

| Year | Population | CBR | CDR | NIR |
|---|---|---|---|---|
| 1949 | 20,189 | - | - | 49 |
| 1960 | 25,012 | 42.0 | 13.0 | 29 |
| 1970 | 31,435 | 32.1 | 9.4 | 22.7 |
| 1980 | 37,407 | 23.4 | 6.7 | 16.7 |
| 1990 | 43,390 | 16.5 | 6.0 | 9.5 |
| 1992 | 43,663 | 15.4 | 5.8 | 9.6 |

source: NSORK(1993), Social Indicators In Korea, Seoul, NSORK, p.41.
Notes: CBR;crude birth rate, CDR;crude death rate, NIR; Natural increase rate

Population policy included direct and indirect measures influencing births, deaths, and migration of people in general(Chang,1993,p.53). In the early 1960s, the birth control program evolved primarily in response to the high level of birth rate. However, from the early 1970s the policy was focused on a small family norm. The slogan was publicised: 'Daughter or Son, stop at two and bring them up well'. From the beginning of the 1980s, population policy, especially birth control measures, had heavily connected with integration with other social development programmes. The policy was instituted in the course of implementing the Fifth Five-Year socioeconomic development Plan(1982-86) (Lee,1993, p.112). The primary content was improving the management of the existing family planning organisation, strengthening various social supports to instil the value of having fewer

children, and establishing a system for inter-ministerial cooperation (Chang,1993,p.59). Owing to these measures, as table 1-1 demonstrates, the result of the recent rate of population increase keeps to a very low level.

## Population structure

It is commonly said that the structure of population is seen as a major challenge to social and health services and affects the support of elderly people in many industrialised countries. This connection is relatively new to Korean society. However, Korea is also alarmed by a rapidly increased proportion of elderly people in the total population and by the decreased potential of informal caregivers.

The population structure of Korea has drastically changed over four decades(see table 1-2). In terms of overall population structure, the proportion under 14 years of age was 42% of the total population in 1970. However, the proportion of this group dropped to 34% in 1980 and 26% in 1990. On the other hand, the proportion of the population at an age to be involved in economic activity had steadily increased about from 55% in 1960 to 70% in 1990 of total population. The elderly population had increased from 0.98 millions(3.9%) in 1960 to 2.01 millions(4.7%) by 1990.

The elderly population increased by 1.03 millions over 40 years between 1960 and 1990. It is anticipated that it will continue to increase and will reach around 4.0 millions(7.4%) by the year 2005.

Table 1-2: Changes in the age structure of population and projection in Korea, per 10,000 persons(%)

| Year | Total Pop. | Age group 0-14 | 15-64 | 65+ |
|---|---|---|---|---|
| 1960 | 2,501 | 1,015(40.6) | 1,390(55.6) | 98(3.9) |
| 1970 | 3,224 | 1,357(42.1) | 1,760(54.6) | 109(3.4) |
| 1980 | 3,812 | 1,196(34.0) | 2,371(62.2) | 145(3.8) |
| 1990 | 4,279 | 1,108(25.9) | 2,970(69.4) | 201(4.7) |
| 1995 | 4,596 | 1,160(25.2) | 3,197(69.6) | 240(5.2) |
| 2005 | 4,971 | 1,058(21.3) | 3,544(71.3) | 369(7.4) |

Source: NSORK(1991), Population projection(Yoon,1995,p.9)

As mentioned in the introduction, while there will be a relatively low proportion of elderly people in the total population, compared to other developed countries such as Japan and the UK, yet it is expected that Korea will confront a similar proportion of elderly people to advanced countries in the near future. One of the crucial causes of this phenomenon is the increasing life expectancy. As shown in table 1-3, average life expectancy had increased 55.3 years in 1960 to 71.3 in 1990. There may be more women than men because women have a longer life expectancy. This advance is mostly due to improvement in sanitation, the discovery of antibiotics, and medical care advancement(Rhee, 1995,p.60).

Table 1-3: Life expectation from 1960 to 2021 In Korea age

| | 1960 | 1970 | 1980 | 1990 | 2000 | 2021 |
|---|---|---|---|---|---|---|
| Average | 55.3 | 63.2 | 65.8 | 71.3 | 74.3 | 77.0 |
| Male | 53.0 | 59.8 | 62.7 | 67.4 | 71.3 | 74.9 |
| Female | 57.8 | 66.7 | 69.1 | 75.4 | 77.4 | 79.1 |

Source: Choi,SJ.(1993), long-term direction of social policy for elderly people, Social welfare, p.63

On the other hand, another aspect of demographic structure which influences welfare service provisions is the decrease in potential caregivers and supporters for elderly people

within the family system. There are three changes that have caused particular anxiety, namely, increasing divorce rate, married women's work participation, and decreasing family size.

Firstly, divorce and subsequent remarriages have increased substantially in the past decades in Korea. As table 1-4 shown, the trends in divorce dramatically increased during the 1980s.

Table 1-4: The growth of the divorce rate in Korea

| Year | Total cases of | | Divorce rate per | |
|---|---|---|---|---|
| | Marriage | divorce | 1,000 persons | 100 marriages |
| 1970 | 295,137 | 11,615 | 0.88 | 3.94 |
| 1980 | 400,471 | 23,150 | 1.83 | 5.78 |
| 1989 | 343,285 | 45,039 | 3.12 | 13.12 |

Source EBP, vital registration statistics(Chang,1993,p.245)

The increase in the divorce rate led households to increase a diversity of type of composition such as single parent and children, grand parents and grandchildren, and three or four-generation families without intermediate generation. It means in certain cases that elderly people have to take on a role of caregivers rather than care receivers within households. Secondly, married women are encouraged to enter the work force in increasingly larger numbers than in the past, due to the prolongation of women's post-child care lives and increasing well-educated and middle class married women who seek the maintenance of a professional career. Table 1-5 indicates evidence that married women(75.5%) in 1990 are more likely than those(72%) in 1980 to be in a labour market. As a result, the family care for elderly people in Korea is, from another aspect, a burden because a married woman has to carry out both professional and caring work for the elderly.

Table 1-5: Percentage of married employed female in total employed female in Korea

* 1,000; persons, **%

| | 1980 | 1990 | 1992 |
|---|---|---|---|
| Total female employed * | 5,222 | 7,341 | 7,609 |
| Single ** | 28 | 24.5 | 24.9 |
| Married female ** | 72 | 75.5 | 75.1 |

Source: NSORK(1993), Social Indicators In Korea, Seoul, NSORK, p.83

Thirdly, a factor affecting care provisions for elderly people in Korea is the decreasing family size, and family composition in transition. The trend of sizes of households for the whole country is shown in table 1-6. The average size of household has been lost from 5.49 persons in 1966 to 3.71 persons in 1990. As many as two persons were reduced in the course of one generation. Moreover, the proportion of three or four-generation families fell from 23.2% in 1970 to 12.4% in 1990.

Table 1-6: Average family size and composition of ordinary household in Korea *persons, %**

| | 1966 | 70 | 75 | 80 | 85 | 90 |
|---|---|---|---|---|---|---|
| Whole nation * | 5.49 | 5.24 | 5.04 | 4.55 | 4.09 | 3.71 |
| Urban * | 5.1 | 4.9 | 4.9 | 4.4 | 4.0 | 3.7 |
| Rural * | 5.7 | 5.5 | 5.4 | 4.7 | 4.2 | 4.0 |
| 1GF** | - | 6.8 | 6.7 | 8.32 | 9.6 | 10.7 |
| 2GF** | - | 70.0 | 68.9 | 68.5 | 67.0 | 66.3 |
| 3GF** | - | 22.1 | 19.2 | 16.5 | 14.5 | 12.2 |
| 4GF** | - | 1.1 | 0.9 | 0.5 | 0.4 | 0.2 |

source: * Census,1966-1990(Chang,1993,p.127)
** NSORK(rspective census year), population and housing sensus Report(Yoon,1995,p.18)
Notes: GF; Generation Family

However, it is characteristic that the two-generational family has slowly been diminishing and the one generation family has rapidly increased. In short, the family composition in Korea has been transformed from the type of

an extended family to that of a nuclear family. Considering that the majority of elderly people who are cared for by a family belong to a three-generation family, the transition of family composition of household in Korea as a whole is different from the pattern affecting elderly people.
These trends imply that the availability of care for elderly people by offspring within their family may be shrinking.
To sum up, the rapid decrease in the fertility rate accompanied by the increase in average life expectancy is one of the causes for a rapid increasing proportion and number of elderly people in the population structure. The most immediate obvious demographic change has been the rapidly reduction in family size and signs of family composition in transition, which has brought about other subsequent changes in the welfare field. All these demographic changes have partly forced policy makers to develop public services for the care of elderly people. Thus, family care in transition has been confronted by the public services in the form of community care for elderly people.

## SOCIO-ECONOMIC FACTORS

The wider contexts of social policy, according to Tester (1996), are particularly dependent on the economy and economic policy. Major changes in principles and practice of social welfare often follow economic crises and recessions in Western countries(p.13). In a similar vein, according to Usui(1988), Flora and Alber(1981), and Meyer(1980) socioeconomic conditions are considered to be one of the crucial factors for the growth or decline of welfare services(p.1). In this section, we investigate how much

interrelationship exists between socioeconomic factors, in particular industrialisation and urbanisation, and the development of welfare services for elderly people in Korea.

## Industrialisation

The term 'industrialisation' was originally used to refer to machine production, the basis for an enormous growth in productivity, but in modern times it refers to a mode of economic growth(Kemp, 1978,p.9). In this study, the latter is more emphasised than the former.

In Korea, it can be explained that the characteristic of industrialisation is a rapid decline of agriculture sectors. On the other hand, a sharp increases in the fields of manufacturing industry and service sectors since the independence from Japan in 1945(see table 1-7).

First of all, land reform(1947), then the Korean War(1950-1953), and the Five-Year Economic Development Plan played a significant role in transforming the industrial structure. After independence from Japan in 1945, A National Land Reform Administration(NLRA) was established as an agency of the state to acquire by compulsion privately-owned land at a 'standard price' of three times the value of the annual crop. Land so acquired, plus the land confiscated from the Japanese, would be sold at the 'standard rate' to tenants and others in accordance with priorities assumed to reflect the relative fitness of various types of families to take over its operation(You,1986,p.14). With the Land Reform, there was no longer any landlord class and the former landlords had an opportunity to invest their capital in industry. Therefore, the economy development was encouraged in urban areas and a

part of the overgrown rural population was drained to urban areas. It was seen that Korea could have undertaken industrialisation in its real sense.

Table 1-7: Composition of an employed person by industry in Korea %

| Year | Agriculture Forestry & fishery | Manufact-uring | Service & others | Total |
|---|---|---|---|---|
| 1940 | 80.2 | 4.2 | 15.6 | 100 |
| 1960 | 65.4 | 10.1 | 15.0 | 100 |
| 1970 | 50.4 | 14.3 | 35.3 | 100 |
| 1980 | 34.0 | 22.5 | 43.5 | 100 |
| 1990 | 18.3 | 27.3 | 54.4 | 100 |
| 1992 | 16.0 | 25.5 | 58.5 | 100 |

source: NSORK(1993), Social Indicators In Korea, Seoul, NSORK,p.75 & Census,1960
Notes: Manufacturing included mining sector, missing 1950 due to Korean War.

However, the Korean War (1950-53) did crucial damage to her industry. Lee, K.B. describes this:

"About 43% of manufacturing facilities, 41% of electrical generating capacity, 50% of the coal mines, and one-third of the nation's housing was destroyed"(Lee,1984;Chang,1993,p.40).

Rapid industrialisation in Korea was launched with the First Five-Year Economic Development Plan in 1962. As shown in table 1-7, the structure of industry sectors had dramatically been changed. About 65% of employed people in 1960 were in agricultural, forestry, and fishery sectors but, the figure had dropped to around 18%. On the other hand, manufacturing(10 to 27%) and service(15 to 54%) sectors had increased for three decades between 1960 and 1990.
Connected with economic growth, industrialisation is generally measured by per capita income in a country. Economic growth was remarkable for the last 40 years. Per

capita income had grown from US $ 65 in 1955 to US $ 6749 in 1992 in Korea.

Table 1-8: Increase of per capita income between 1960-1995 US $

| year | 1955 | 1970 | 1980 | 1990 | 1992 |
|---|---|---|---|---|---|
| Per capita income | 65 | 252 | 1592 | 5659 | 6749 |

Source: NSORK(1993), Social Indicators In Korea, Seoul, NSORK, p.59.

The most general type of economic argument maintains that the development of welfare services, such as formal services for community care, is a result of industrialisation (Sigerist, 1943;Usui,1988). The process of industrialisation is considered to be one of the primary sources for creating new social problems, like taking care of elderly people, that inevitably calls for formal welfare solutions in Korea. While an agricultural societal stage had considerable welfare needs, certain welfare provisions could be provided by informal sectors, especially by family networks to meet their needs non-monetary ways. However, in an industrialised societal stage, the majority of people in manufacturing and service sectors depend on cash income and wage work, which bring about a number of new contingencies that can seriously jeopardize individual and family lives. The recent perspectives on welfare services resolve around the notion of needs accompanying industrialisation. The government automatically responds to societal needs in the realms of formal social and health services(Usui,1988,p.11). Therefore, there must be a strong correlation between government spending on the welfare sector and industrialisation. A function of the growth in national wealth could be expressed through the growth of formal welfare services(Park,1993,

p.29). This argument is supported by several writers such as Cutright(1969), Wilensky(1975), and Riminger(1971). Table 1-9 provides some statistical evidence for the argument above. The health and social welfare budget in government expenditure had steadily increased from 6.0% in 1960 to 7.0% in 1980. Welfare services budget for elderly people had strikingly increased from the late 1980s to the early 1990s alongside economic growth(see & compare between table 1-9 and table 1-8).

Table 1-9: Expenditure structure of the government in health and welfare sectors*. %

| Year | 1970 | 1980 | 1990 |
|---|---|---|---|
| Health | 0.9 | 1.9 | 2.7 |
| Social welfare | 5.1 | 3.5 | 7.3 |
| Total | 6.0 | 5.4 | 7.0 |

Trend of welfare service budget for elderly people in total welfare budget**. Unit: %

| Year | 1987 | 1988 | 1990 | 1992 |
|---|---|---|---|---|
| Elderly people | 8.7 | 8.9 | 31.0 | 30.0 |

source: Summary of budget for fiscal year(Chang,1993,p.302* p.299**)

According to a functionalist theory of welfare, the dynamic impacts of the socioeconomic changes associated with social problems have emerged during the industrial transformation of society. The proportion to which formal welfare services emerged and expanded as an integral element in the dynamic of industrialisation is central to many accounts of the development of social policy((Midgley,1986,p.226). One of the criteria for increasing welfare resources available in community care for elderly people is the analysis of the government expenditure for health and social welfare sectors, especially the welfare service budget for elderly people

presented above. This analysis is based on an assumption that much higher budgets for health and social welfare services will entail more quantitative and qualitative welfare services being provided in community care(Kwon,1997, p.470). It is inevitably necessary that financial resources are provided by the government for the development of the most formal welfare services to provide for elderly people in community care, for instance, home help services and home visiting nurse.

However, the debate about increasing welfare expenditure may have acquired new salience with the economic crisis since December in 1997 in Korea. What is the significance of what has happened in the welfare sector after the economic crisis? The only possible answer is that we do not know yet. In the light of Western experience, it is expected that economic constraints should negatively affect both the resources available to welfare expenditure and the cost pressure on particular parts of welfare expenditure such as social services for elderly people. The government is likely to be committed to rolling back the frontiers of the state, in particular to reducing the level of welfare expenditure in order to revive the economy.

## Urbanisation

The term 'urbanisation' has two meanings. One refers to the agglomeration of population to the urban areas, the other refers to change of life styles in rural areas to conform to those of the urban pattern. In connection with community care, both concepts are likely to be influenced.

First of all, as shown in table 1-10, the increase of the

urban population was a significant trend in the late 1940s and 1960s. It was caused by the repatriation after independence(1945) and, as mentioned earlier, as a result of land reform(1947). In addition to these, the North's refugees(1.5 millions before/after Korean War) immigrated into the southern part of Korea during/after Korean War(1950-1953)(Lee,1984;Chang, 1993,p.40). Most of them settled down in urban areas. Furthermore, there was also a post-war 'baby boom'. As of 1990, more than 70% of Korean population has conglomerated in urban areas.

Until the early 1960s, non-economic factors mainly impacted on the immigration of the population into urban areas. However, after the First Five Economic Development Plan(1962), with urban centred industrial development, the trends of capital flow stimulated rural people to immigrate into urban areas(Chang,1993,p.41).

Table 1-10: Population size and proportion of urban to total population Million, %

| Year | Population Total | Urban | Rural | Proportion of urban pop. |
|---|---|---|---|---|
| 1940 | 24.33 | 1.87 | 22.46 | 7.7 |
| 1949 | 20.19 | 3.48 | 16.71 | 17.2 |
| 1960 | 24.99 | 7.00 | 17.99 | 28.0 |
| 1970 | 31.44 | 13.61 | 17.83 | 43.3 |
| 1980 | 37.44 | 21.42 | 16.02 | 57.2 |
| 1990 | 42.80 | 30.64 | 12.16 | 71.6 |

source: Census(respective yes)(Chang,1993,p.41).

Urbanisation impacts on the population structure. Urban areas have provided more opportunities to obtain jobs, education, cultural facilities, and to improve the quality of life for young people. Otherwise, many elderly people would not have been anxious to move from longstanding social networks in the rural community (Ha & Chung,1990; Palley,1992,p. 794). Table

1-11 shows, the comparison of the population structure between rural and urban areas in 1960 and 1990. About 44% of the rural population was aged below 14 in 1960. But, this group of the population had dramatically decreased to only 19% in 1990. However, At the other end of the age range There was about 4% of people aged 65+ in 1960, but around 9% in 1990. The proportion of the population under 14 had sharply declined in rural areas, while that of the elderly had significantly increased.

Table 1-11: The change in the demographic structure by region %

| | 1960 | | | 1990 | | |
|---|---|---|---|---|---|---|
| | Average | Urban | Rural | Average | Urban | Rural |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |
| 0-1 | 42.55 | 41.6 | 43.5 | 23.80 | 28.6 | 19.0 |
| 15-64 | 54.50 | 56.2 | 52.8 | 70.25 | 68.3 | 72.2 |
| 65+ | 2.95 | 2.2 | 3.7 | 5.95 | 3.1 | 8.8 |

Source:Census(1960 & 1990)(Chang,1993,p.57)

Urbanisation has resulted in an increase in inter-generational friction along with lower status for elderly people. The problem for elderly people and family members in three-generation household is that room units are usually too small, leading to friction and lack of personal space (Palley,1992,p.790). The absolute number of the population has increased faster than the growth in the housing stock in urban areas(Chang,1993,p.153) and new housing is often quite expensive and too small to accommodate the needs of elderly parents in multi-generalisation families(Palley & Usui, 1995, p.243).

The other aspects of urbanisation in rural areas are life style including family system, family structure, kinship boundaries, role distribution and power have changed to those

of the city. The urbanisation out of country side can be explained by ideological change. Thanks to economic and per capita income growth, life patterns in rural area have been becoming more individualistic and materialistic as a by-product(Hong,1987,p.121). The younger generations are pursuing their values to emphasize individual rights and duties, casting off the group characteristics of the traditional family. Individualism could not help but have an affinity with a small nuclear family(Chang,1993, p.149). As a result of the preference for individualism, the family tie required for the care of elderly people within households has been weakened by the urbanisation of rural areas.

It can be concluded that industrialisation and urbanisation have challenged and modified traditional perspectives on elderly people in a family system and led elderly people to being of relatively low status in Korean society. In the traditional Korean family and society, elderly people were respected for their wisdom and knowledge. As the most important member of the family and society, his/her decision was the most influential in shaping the direction of the family and society. In the process of industrialisation and urbanisation, the status of elderly people as decision-makers in family society affairs has been changed or weakened . With the emergence of new technology controlled by technical experts, elderly people's social influence in Korean society cannot help but be limited(Shin,1995,p.43). Evidence affecting the phenomenon is presented in the analysis of previous surveys about who should look after elderly parents. As shown in table 1-12, filial duty to parents is not limited to the eldest son only.

Table 1-12: Responsibility for looking after elderly parents in Korea %

| Year/ | I | II | III | IV | V | VI | Total |
|---|---|---|---|---|---|---|---|
| 1979 | 30.6 | 22.2 | 0.6 | 6.6 | 36.6 | 3.6 | 100 |
| 1988 | 25.2 | 17.8 | 0.5 | 35.8 | 15.8 | 5.0 | 100 |
| 1991 | 18.3 | 13.8 | 0.4 | 46.2 | 15.4 | 5.9 | 100 |

Source:EPB(1990), social statistics survey(Chang,1992,p.242)
Notes: I;the eldest son, II all sons, III; daughters, IV sons and daughters together, V; self-reliance, VI; social welfare and others

It has been extended to other sons or daughters(category IV) as well. More than one in five people prefer that parents are cared for by the welfare services(VI) or by them selves(V) in 1991. It can be implied that the duty for all children is the duty of nobody. The boundary of filial responsibility can be vague among children, and parents can be abandoned by each child in turn.

Industrialisation and urbanisation have encouraged the formation of isolated nuclear families and made family care and informal support networks for elderly people weak. On the other hand, increased formal welfare services available for the care of elderly people have facilitated the development of community care for elderly people in Korea.

## POLITICAL CONTEXTS

The previous sections of this chapter to give the background for the evolution and development of community care for elderly people in demographic and socio-economic contexts in Korea. This section explores the way in which political factors have influenced the background of the evolution of

social policy for community care for elderly people. In recent years, more and more elderly people, particularly low-income and childless elderly people, have been receiving formal services in community care, such as home help and home visiting nurse services. But so far the level of benefits received from formal services in community care remains very low. Many elderly people in need are not covered by community care. Community care for elderly people is still in its infancy stage in Korea. The following analysis explains why community care for elderly people is underdeveloped and why policy-makers are now attempting to develop community care for elderly people.

## Political ideology and social policy

Korea was liberated from Japanese colonial rule on 15th August 1945. When Japan surrendered, the Allies decided to divide the Korean peninsula into two zones, the north under Soviet control, the south under American control, as a temporary arrangement until a Korean government could be formed. The temporary arrangement has led to a division of Korea until the present day(see Korea in introduction).
The Republic of Korea(ROK) was born with a new constitution promulgated in July 1948. One month before, Syngman Rhee was elected the first president of the Republic of Korea. Shortly after the first ROK was born, North Korea, with a communist regime, invaded the Republic of Korea and the signing of an armistice treaty in July 1953 left the boundary between the two nations roughly where it had been three years previously(Cherry,1993,p.24). The Korean war had significant consequences for later political ideology and social policy

in Korea. After the Korean War, no communist activities were permitted in Korean society. Even a leftist party or the espousal of moderate left policies became dangerous(Lee,1997, p.141). Therefore, Korean politics since the Korean War have been continuously occupied by the Right-Wing(Conservatives). Another important factor influencing social policy in Korea was the American Occupation Authorities(AOA)(1945-1948). The AOA introduced a 'market ideology' into the welfare sector, including medical services such that private services were emphasised. The state's monopoly on social functions was banned and the establishment of private welfare institutions was encouraged by the AOA through the means of considerable relief aid. (Chung,1992; Lee,1997,p.165). These two main factors established in the late 1940s and early 1950s, conservative political ideology and market ideology, led the Korean government to give little attention and effort to enhancing the state's capacity for the social welfare services until 1990s.

The first and second republics of Korean government (1948-1960) could not establish modernised social welfare provisions. The period was more characterised by political concern than with economic and social problems. The main social policy taken by the government was to provide the necessities for refugees, homeless people, and disabled veterans(Lee,1997,P.166).

Through the 1960s, minimal provisions relevant to social welfare services were introduced and revised from old colonial laws by the military regime(1961-62)and the third republic of the Korean government(1963-1971), such as the Living Protection Act(1961), Disaster Relief Act(1962), Medical Insurance Act(1963) and the basic law for the Social

Security System(1963), pension schemes for military personnel and government employees. Many of these were suspended, not to be put into effect until the late 1980s onwards. However, the schemes for military personnel and government employees were implemented(Park,1993,p.110). The new military government might have needed to create legitimacy and to secure sovereignty. Evidence for this is that the conservative ideology on welfare policy also appeared in this era. Another source of minimal provisions kept by the government was due to a high percentage of defence expenses in total government expenditure due to geo-political and historical conditions with a divided nation-state and the Korean War. As table 1-13 shows, such a huge defence spending has been associated with a small increase in social welfare expenditure.

Table 1-13: Social development and defence expenditures (1965-1990)in Korea billion of Won,(%)

| Year | 1965 | 75 | 85 | 90 |
|---|---|---|---|---|
| Total | 93.5 | 1,535.3 | 15,000.3 | 32,536.9 |
| SDE | 5.0(5.4) | 61.2(4.0) | 843.3(5.6) | 2,450.3(7.5) |
| DE | 29.8(31.9) | 442.4(28.8) | 3802.5(25.3) | 6856.2(21.1) |

Source:Ministry of Finance(1990), various issues of summary of financial statistics(Lee,1997,p.167)

Notes: SDE; social development expenditure(as % of government expenditure), DE; defence expenditure(as % of government expenditure), SDE include the expenditures for health, housing, social security, and human resource development.

In addition to this, political-economic policy and export policy drives enforced the development of welfare provisions to be regarded as secondary importance (Lee,1993,p.113). Korea switched from an import-substitution to export-led strategy of economic industrialisation(Kihl,1994,p.46). Rapid industrialisation in the 1960s produced in part an important

social and economic basis for the development of social welfare services for the 1970s.

The government shifted a development policy emphasis from the economic growth-oriented one to a broader social development (Park, 1993, p.111). The National Welfare Pension Programme (1973) and Medical Insurance Program(1976) were formulated, but implementation of the pension programme was postponed until 1980s and the medical insurance programme only began to provide its benefits to certain groups of society in 1977. The national Welfare Pension Programme also was suspended by the conservative ideology.

Policy-makers believed that filial piety for elderly people was still strongly kept alive in Korean society and the proportion of elderly people was not a serious enough problem for them to initiate social policies to cope with(as of 1973, the portion of the aged was 3.3% in Korea). The first oil shock in 1973 allowed postponement and made the new policy dormant for 13 years until it was revised and up-dated in 1986 and finally put into effect in 1988(Lee,1997,p.180).

In the beginning of the 1980s, even the new military government, the fifth republic of Korean government, publicly made as its slogan 'the construction of welfare state'. The legacy of Confucianism for residualised services was clearly evident in the process of welfare policy implementation(Kihl,1994, p.50). Two examples of this were the Elderly Welfare Act(1981) and the Respect-For-Aged Charter(1982) in order to enact and promulgate for promoting the traditional filial piety and respect for elderly people(see section one in chapter four). Professional and elderly interest groups such as the Korean Senior Citizen Association, the Korean Institute on Gerontology had

increased pressure to develop formal services for elderly people. Thus, the Korean Aging Policy Act of 1982 outlined the government approach to services and policies for elderly people. However, its primary features were an emphasis on tax incentives, awards, and honorifics to encourage families to provide care for elderly people(Palley, 1992,p.797) rather than an increase in formal services.

The general election of 1985 gave a great shock to the ruling party - it lost about two-thirds of its national assembly seats. In September 1986 the government announced three measures for the promotion of social welfare programme: a minimum wage law, the national pension programme, and expansion of the medical insurance programme to the entire nation(Lee,1997,P.188). Medical insurance for residents of farming and fishery villages in 1988 and for the urban residents in 1989 was increasingly expanded with the co-operative system in which numerous self-supporting insurance societies were organised. The implementation and expansion of the national pension programme began in January, 1988. The programme applied compulsorily to most employees between the ages of 18 and 60(Choi,1995,p.129). The government plan applied to all the people including self-employed in urban and rural areas by the late 1990s. While in 1990, only 2% of those of 65+ received a public pension, about 15% by the 2010 and about 50% in 2040 will get a pension (Park, 1989;Palley, 1992, p.798).

From the early 1990s the new welfare policy direction was installed. The western socio-economic influence (golobalisation and Super 301 of USA) with the rapid growth of needs for social services led the government to emphasis the policy of a mixed economy of welfare(Park,1990,p.35). The

notion is the shared responsibility of informal, voluntary, private, and the state sectors. The emphasis in social policy has shifted away from informal services to encouraging private sectors, particularly to meet the needs of elderly people. It did so by financial and technical support to the private sector. One recommendation suggested by the Elderly Welfare Act 1992 is that 'the welfare authorities may give proper financial and technical support to those who are involved in the home service for elderly people in order to improve of the quality of life'(Article 11).

In sum, political ideology in Korea has not changed over the past decades. The major political ideology which has prevailed is Right-Wing(Conservative), which had been strongly influenced by the Korean war. A series of social policies over the last several decades may be seen as a part of an evolving government strategy in Korea. Firstly, the nation-building imperative assumed that rapid growth would result in significant improvement in general welfare for the mass of the population; secondly, the geo-political factor explained why a huge defence spending would be enforced and thus limit social welfare expenditure; thirdly, strong Confucian ethics led the government to introduce the residualisation of social services; fourthly, international socio-economic influences linked to increasing needs for welfare services would press the government to introduce the mixed economy of care; fifthly, in addition to these, social policies were used as a means of political legitimation. As we have seen, the Korean authoritarian government suffered from a weakness of political legitimacy. Most major social welfare programmes were initiated and developed at a time of political crisis.

# CONCLUSION: IMPLICATION FOR COMMUNITY CARE FOR ELDERLY PEOPLE

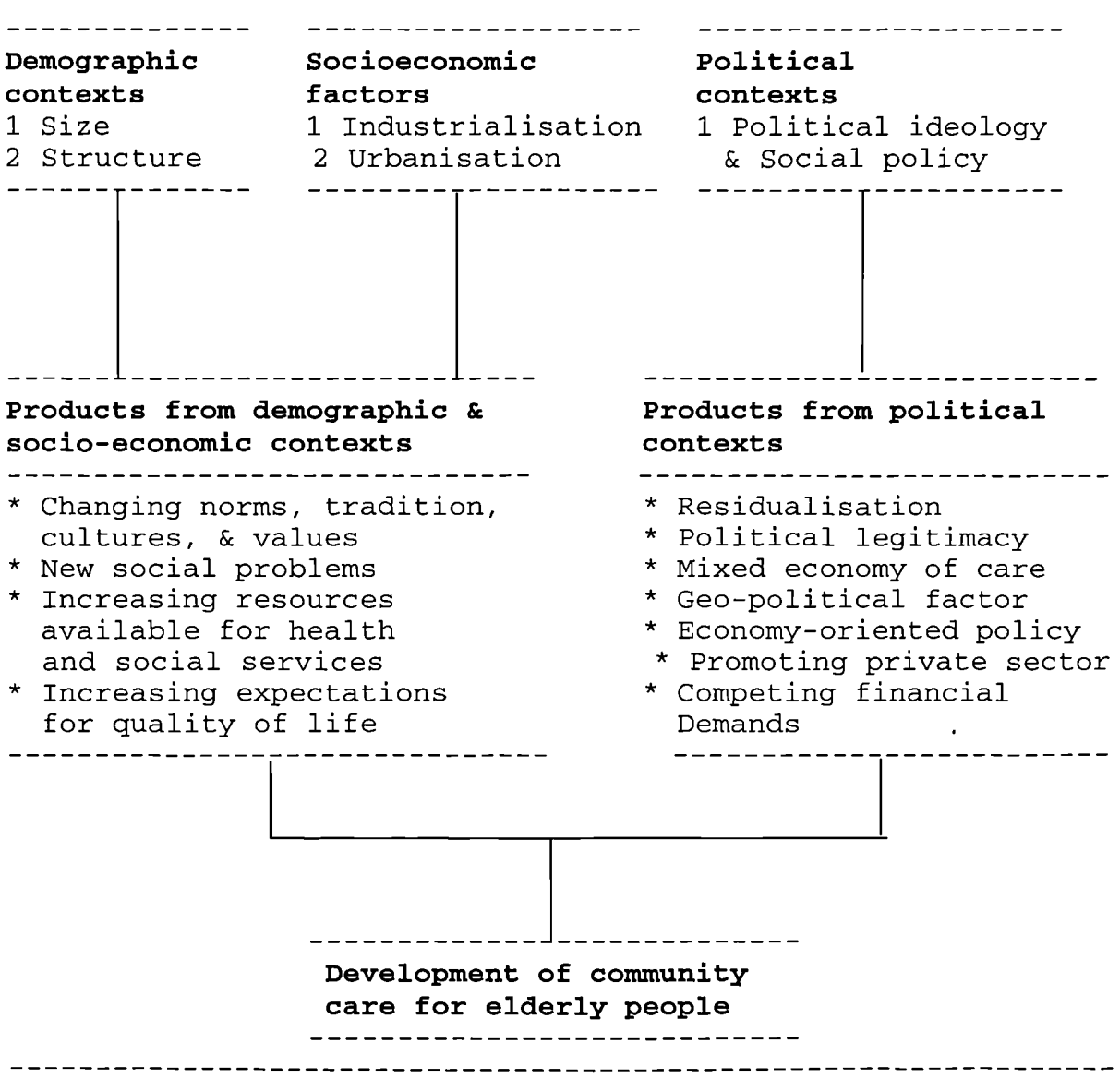
This chapter has examined background material relevant to the emergence and development of community care for elderly people in Korea, especially demographic, socioeconomic, and political factors. But it cannot be said that those the policies mentioned so far are adequate to explain fully the development of community care in Korea. For example, elderly people's preference to stay in their home is regarded as a major issue in the development of community care for them. Most Korean elderly people are ashamed of being sent to institutional care provisions. As a result, the proportion of elderly people staying in institutional care is only 0.3 % of the total elderly population in 1997(see section in chapter five).

The background can be clearly observed by a series of indicators: changing demographic size and structure, especially the increasing number and proportion of elderly population seen as care receivers; and also the decreasing number and proportion of the younger generation acting as informal care givers(see figure 1-1). The socio-economic changes, with associated social problems, that emerged during the industrialisation and urbanisation of Korean society dynamically impact on the evolution and development of community care for elderly people. Industrialisation has created social problems, and should supply substantial financial resources for the development of formal services in community care for elderly people. However, it is expected that the current economic constraints will lead policy-makers

to emphasize the development of informal care and the voluntary sector rather than state services in community care for elderly people.

In terms of the political context, the development of community care results from redefinitions of social policy by policy-makers. They encourage community care for two reasons: one is that care in(by) the community concurs with Korean experiences and tradition, thus making it more acceptable; the other is a financial consideration, that a mixed economy of care can enable government to lessen its direct contribution. It can be assumed that the development of community care for elderly people is mainly to meet some organisation's aims. However, the policy for the development of community care for elderly people appeals to humanitarian ideas as well.

Figure 1-1: Diagrammatically represents key factors in the emergence of community care in Korea



# CHAPTER II

# CONCEPTS, THEORIES, AND PREVIOUS STUDIES

This chapter reviews the theoretical underpinning for community care, and care management for elderly people. The issues raised in this study derive from problems of a more general nature that arise when we seek to apply social theory or concept to any area of applied study (Pinker,1971,p.xi). The issues are intensified by the fact that the provision of community care, like other forms of human behaviour, can only be fully comprehended by calling on a wide range of theoretical disciplines. These include politics, economics, psychology, sociology, and philosophy (Forder,1974, p.xi). Attempts to understand the nature of community care and the nature of the relationship between elderly people and community care have been made by many social scientists, such as Walker, Bulmer, Willmott, and Abrams. They assert that the dynamics of the relationship may be seen to be governed partly by the economic and political contexts of society, and partly by the prevailing socio-cultural or ideological meaning. On the other hand, Challis(1996, personal conversation) argues that care management is a policy driven or motivated subject rather than a concept and practice based on well developed social science concepts and theories. This is reflected in the debate about training for care management, with many people seeing it as a straight forward, common sense activity with no advanced skills based on

theoretical training. We inevitably have to consider various definitions of associated concepts and categorised labels of care management by building upon trends previously established in the research, intended to contribute to the policy making, as well as to implementation and evaluation of community care and care management.

The first section sets out how community concepts may be understood as part of the social construction of the activity of community care, seeing why community concepts have played a significant role in the evolution of community care. We then discuss concepts of community care. The concepts derive from particular ways of thinking and make sense in relation to context, such as the sociological, ideological, political, and economic circumstances. These considerations are central to the understanding of how concepts of community care are currently used, and what and whose purposes they may serve. The research and writings by western sociologists, referring to western societies, have mostly been reviewed for the study. Thus, at the end of this section concepts of community and community care are related to community care for elderly people in Korea. However, there is little research and writings on the concepts of community and community care that refer to Korean society. The term 'community care' is used here in an action-oriented, policy-oriented, rather than a problem-oriented, stigma term. It can be taken to refer to the principles that govern action directed towards given ends. The concepts denote action about means as well as ends and it, therefore, implies change - changing situations, systems, practices, behaviour (Titmuss,1974,p.23).

Section two of this chapter examines social theory and concepts which are of particular importance in the conduct

of care management and identifies the models of care management. The relative recency of care management means that there is a limited amount of empirical research available to draw upon to shape theory about the services. In addition, there is a lack of uniformity in areas such as appropriate measurement instruments and operational definitions. This makes it necessary to be cautious and tentative in applying the theory in practice(Rothman, 1992,p.8). This part provides a basis for understanding the theoretical nature of the relationship between community care and care management.

Section 3 details the findings of international studies in such countries as the USA, the Netherlands, and Japan. This section focuses on how care management has been implemented in practice.

## RELEVANT SOCIAL SCIENCE WRITINGS

### Concepts of community

We have used the word 'community' to describe a wide variety of social units over time. According to Mayo(1994, pp.49-50), Williams(1976) pointed out in his critical collection, *Keywords*, that 'community' has been in the English language since the fourteenth century. Originally it was used to refer to the common people, as opposed to those of rank, or to a state or organised society. From the sixteenth century, the term was used in three different and competing ways: 'holding something in common, a feeling of common identity and most positively of all, a quality of mutual caring in human relations'. From the nineteenth century, the term was used

to contrast 'communities' and localities with larger, more complex industrial societies(Mayo,1994,p.49). However, no one seems to agree on the concept of community. As argued by Bell and Newby(1971):

"In considering the concept of community, the sociologist shares an occupational hazard with the architect and the planner: the more he attempts to define it in his own terms, the more elusively does the essence seem escape him...What the concept involves has not proved too difficult to evaluate; attempts to describe what it is, however have proved impossible without making value judgements"(p.21).

Alhough the argument mentioned above implies some difficulties for any study of community, due to little agreement on the use of the term, the desire in sociology for a single definition of community is understandable, in a discipline aiming at precise and scientific observations. Attempts to research such a definition, according to Bell and Newby(1971), led to the classification of ninety-four types by Hillary in 1955. The major division was between generic and rural community. Next, he succeeded in abstracting sixteen concepts, related in twenty-two different classifications. However, he also said that 'beyond the recognition that people are involved in community there is little agreement of the use of the term'(p.28). Bell and Newby also concluded, on Hillary's classification, in their book, *Community Studies,* that:

"Not all the definitions can be correct...A community can not be an area and not be an area, though significantly Hillary found that no author denied that area could be an element of community"(p.29).

They then attempted to examine ways of classifying communities as types, localities and network, and the ecological and objective approaches.

*Communities as types(the rural-urban continuum)*

Treating communities as types is the closest approach to the tradition of Gemeinschaft-Gesellschaft. This typological approach to communities is a theory of social change - its aim is not merely to classify communities 'like so many butterflies, but also to say something about the nature and direction of social progresses'(Bell & Newby,1971, p.42). But, in actual practice, the rural community came to represent one, and the urban the other(Bernard,1973,p.91). Studies done of communities as types have essentially referred to 'the changes that have taken place in the nature of human relationships, when preindustrial systems were integrated into a wider industrial system'(Bernard,1973, p.92).

There are some patterns of variables to identify between Gemeinschaft and Gesellschaft: immediate self-gratification or its deferment is expected; scope of relation is narrow or wide; action is governed by generalized standards; and ascription or achievement(Bell & Newby,1971, p.26). However, there are a number of criticisms that can be made of this typology. The main problem lies in identifying a type of social relationship with a particular spatial form, as social relations do not vary uniformly across space. According to Pahl, Gemeinschaft relations are found in cities and Gesellschaft is likewise common in rural areas(Pahl,1975; Gilbert, 1982,p.168). The typology also focuses attention on the urban as a source of social change and obscures the wide range of values and ways of life of individuals at the folk end of the continuum(Bell & Newby, 1971;Effrat,1974,p.9). Gusfield(1975) argued that:

"Gemeinschaft and Gesellschaft do not describe any known, actually existing society nor any of historical existence. They are analytical and not empirical terms; concepts invented to help the analyst think about and talk about change and human association. As such, they are products of human imagination and not descriptions of a real world"(p.11).

Communities as types may fairly well describe some communities, especially in the past, but the paradigm fails to provide a satisfactory explanation of community in its familiar present-day aspect of society.

*Community as locality and network approach*

Locality has so frequently been posited as an essential condition for community that the term is sometimes coterminous with territory(Gusfield,1975,p.32). The community basically refers to people having something in common, and this shared element is often understood geographically (Willmott,1986;Crow & Graham,1994,p.3). Although seventy-three of the ninety-four definitions from the literature of these fields examined by Hillary in 1955, according to Effrat(1974), included place as one of the major defining characteristics of a community (p .4), there are a number of arguments against community as locality:

"(a) they are mere description; (b) they are works of art, idiosyncratic and non-replaceable; (c) therefore it is argued that they are of no use to a science which must be based on the comparative method; (d) that they are committed to a holistic approach to sociological theory; and (e) that they abstract from empirical social reality at a point where such abstraction is neither feasible nor useful"(Stacey,1969,p. 137).

A variety of structural and technological developments, and the importance of common affiliations in modern life have liberated communities from the confines of locality to more

broadly based ones(Perry,1986,p.117).

A *network* approach mainly focuses on the nature of alternative, nonspatial forms of community, using a methodology developed largely from social anthropology (Effrat,1974,p.19). In this conception, a community is a group of people who share a range of institutions on the basis of their belonging to some familiar social categories (Effrat,1974,p.3). In a similar vein, Bell & Newby's sense of community, with its adoption of Stacey's term 'local social system', implies that individuals are linked together in social networks. It was quite explicitly focused on those informal, largely non-institutionalised relationships which were at the heart of community solidarity and conflict. It provided a means of mapping out the full set of informal relations to which any individual was party and then linking the connections between these others(Crow & Graham,1994,pp. 179-181). Network analysis is seen as 'being the most fruitful direction for future study on community'(Crow & Graham,1994,p.117). However, although a network approach allows the examination of a wider range of relationships, irrespective of geographical bases, community as a network confronts two unhappy deficits - ignoring the general understanding of community and neglecting the questionable nature of community in geographic settlement (Perry,1986, p.265).

*The ecological approach and community as organizations*

The ecological model is an offshoot of the structure-functional or social systems paradigm as applied to one particular aspect of the community. According to Bernard

(1973), there are three aspects of the ecological paradigm: 'the units involved in community structure'; 'the spatial arrangement of these units'; and 'the underlying process which generated them and the process that determined their relationship with one another'(p.34). The result of similar demands on the environment and a similar ability to pay for them is involved a rough kind of homogeneity, never complete, always relative, but always expectable(Bernard,1973,p.36). The ecologist has a distinctive view of community, regarding the solidarity and shared interests of community members as a function of their common residence (Bell & Newby,1971, p.33). The ecological model provided sharp and accurate descriptions of the spatial aspects of communities. The question of how men can relate themselves to one another in order to live in their habitat yields a description of community structure in terms of its overt and measurable features(Hawley,1950; Bell & Newby,1971, p.43). Although the community structure is criticized, the investigators usually minimize issues of power and inequality by overemphasizing consensus, co-operative competition(Miley, 1980; Gilbert, 1984,p.623), yet their work illustrates some important aspects of community by means of insights into biological organization.

There is another approach that also treats communities as organizations in a sociological sense. *Communities as organizations* are social arrangements for achieving desired goals(Bell & Newby,1971, p.36). According to Bell & Newby (1971,p.38), Hillary(1955) argued that:

"The defining characteristic of an organization...is the 'primacy of orientation to the attainment of specific goals'. This feature distinguishes organizations from such groups as the family, local communities, and of a society conceived as a whole".

When we use the term 'community' in terms of objectives, It is apparently a review of communities as organizations. Willmott and Thomas (1984) suggest a threefold distinction in their book, *Community in Social Policy* - territorial community; interest community; and community sense. They see territorial communities as the population of a particular geographical area, or people who have in common something other than physical propinquity. It relates to places to which the term 'neighbourhood' could be applied. For the second usage the term 'interest community' is the self-help or mutual aid group, composed of people who have a common condition or problem that has importance. Community sense can be present in varying degrees in both territorial and interest communities(pp.4-5). When we see community as organization, we must also imply much more about the style of social relationships and people's conceptions of community, their psychology, attitudes, sentiments, and motivation.

## The sociological contexts of community care

Community care involves various provisions of care and support from statutory, commercial, voluntary and informal carers. The ideas with which this work deals are a mixture of sociological propositions about the nature of modern community life, including personal ties between, in particular, relatives, friends and neighbours (Bulmer,1987, p.ix). The direction of social change in modern community life drives towards greater social mobility, dispersed kin network, increasing privacy and decreasing solidarity. This section aims to understand how the sociological contexts in

which community care is provided is changing. It begins with variations of social services in a community, according to the direction of social change and changing solidarity. Following this is a primary group and social network that play a crucial role in community care.

*Gemeinschaft-Gesellschaft and changing solidarity*

As mentioned in the previous section, Gemeinschaft and Gesellschaft is the best known sociological paradigm to explain the direction of social change. In thinking about community care, it is recognized that formal caring relationships could be placed in human relationships of Gesellschaft, while informal caring relationships could be applied to that of Gemeinschaft. It is postulated that to attempt the transition from Gemeinschaft to Gesellschaft is the transformation from the type of informal care by primary group to that of formal care in a community. The primary group has a strong sense of belonging together. Thus, we characterize the folk society as small and homogeneous with a strong sense of group solidarity and informality (Redfield, 1947; Bell & Newby,1971, p.44). This strong sense of solidarity involves a close identification of the members with one another. It is noteworthy that appeals to common membership, and communal feelings, so often use the language of kinship:'You and I are not strangers but are part of the same community and therefore should act differently than we each would toward strangers'(Gusfield,1975,p.26).
We view solidarity multidimensionally; emphasizing behaviour, structural, and perceptional linkages of individuals to their community of residence(Gooud,1990; Stinner et al.,1990.

pp.495-496). Consequently, solidarity plays an important role in explaining why community members or kin are involved in informal care in a community. However, solidarity can hardly be a constant in a community which is rapidly changing in nearly all other respects(Daatland,1990,p.2). The loosening of solidarity takes several forms. Contact with kin, particularly between parents and grown-up children - themselves married - is maintained by the motor and telephone. In times of need, one can call or travel to another, but day-to-day local contact has more typically been replaced by week-to-week or monthly contact from a distance. Another major factor in this is the spread of mass-media, in particular television. It is a source for an increasingly family centred culture (Bulmer,1987,p.55). All these factors permit social contact to be maintained other than on a face-to-face basis between family members in a community. It means communal solidarity declines, leading to increasing privacy in a community. Changes which have taken place in social solidarity have considerable implications both for the character of local social networks and for the provision of informal care by the primary group in community care ((Bulmer,1987,p.52).

*Primary group and social network*

People interact with one another in a variety of different settings, at work, in commerce, as well as through informal ties. Many such social interactions are structured and institutionalised. The primordial or primary interactions, on the other hand, are established on the basis of affect, tradition or propinquity (Bulmer,1987,p.38). People spend

considerable amounts of time engaged in primary interaction in a community. This is because primary interaction underpins how society and the community function. It provides them with pleasure and satisfaction. According to Brigden & Todd(1993), it is a powerful and effective social reinforcer in a community(p.81). Common social reinforcers produce the provision of care and support for dependent people in a community. Community care appeals to the idea of a past society with a dense interlocking of primary personal ties in which people took responsibility for each other and social support was available for those in a state of dependency (Bulmer, 1987, p.38). Bulmer(1987,p.43) argues that 'most primary groups defined by Cooley(1909) who developed the term primary group, are the family, the play-group of children, and a neighbourhood or community group of elderly people'. These are practically universal, belonging to all times and all stages of development, and are accordingly a chief basis of what is universal in human nature and human ideals(ibid). Therefore, community care is non-exist without primary interaction networks in need of support and care from kin or family, neighbours, and friends.

The family or kinship group is the main source of social care, personal aid and support for elderly people through primary interaction in a community. Willmott(1986) observes that 'kinship continues to play a central role and at crucial stages in life remains the main source of care'(p.28). There are good reasons why such family or kin are best for providing care. They can responded immediately to crises, provide everyday assistance, offer emotional reassurance, and supply long-term care of a straightforward kind(Litwak, 1985; Bulmer,1987,p.177). However, some factors - greater

geographical mobility, changes in men's and women's roles, and increased divorce - are the main sources of decreases in primary interaction in kinship.

In terms of their potential for providing care, kin relationships cannot be considered as a single, uniform category. The moral obligation and responsibility that kin feel for one another clearly varies depending on the closeness of the genealogical connection that exists between them(Allan,1983,p.424). Willmott(1986) distinguishes interaction in four types of kinship: a local extended family of the traditional type; the dispersed extended family; the dispersed kinship; the residual kinship network(pp.26-28). The dispersed extended family and the dispersed kinship network are much more characteristic of modern urban society than the rural community.

The personal ties of geographical propinquity between neighbours are another example of primary interactïons. The phenomena of neighbouring, the actual patterns of social interaction observed among neighbours, are potentially important for the provision of social care(Bulmer, 1987,pp.39-40). However, the neighbouring relationship is perhaps in principle the weakest link in any chain of social care (Abrams,1984,p.413). Help between neighbours can be particularly useful in meeting the contingencies of everyday life, especially minor help, looking after pets and plants, visiting elderly people, loan of minor items, short-term help in illness and looking after children(Willmott, 1986,p.57). As these services are relatively minor, they are easily reciprocated and do not normally escalate to involve either side in extensive inconvenience. Abrams, on the other hand, argued;

"simply because of proximity, the potential for neighbours to irritate and come into conflict with each other is quite high. Equally most neighbours value their privacy and do not want their neighbours interfering in their way of life or forever being on top of them. So what is called for is a reciprocal respect for each personal space and the exercise of control over behaviour likely to cause disturbance"(Abrams,1980;Allan,1983,p.429).

The key to understanding the limitations of neighbour care is the realization that the development of important reciprocity-based relationships has become increasingly problematic as a result of social change. The combination of social trends - the increased entry of women into the labour market, increasingly privatized family living, increased geographical mobility, greater availability of formal care and levels of disposable income for the majority - has transformed neighbouring today into being more a matter of choice than of constraint and more influenced by the wish to define privacy than by need for help(Snaith,1993,p.53). Compared with kinship, a neighbour is a much less significant source of informal care and support in a community.
Friendship plays also an important role of social care in a community. The central importance of friendship in modern social care is distinctively based on choice rather than on constraint, on friends chosen within a range of social options rather than on neighbours and relations within implacable social or territorial bounds(Abrams,1984,p.416). On the other hand, Willmott(1986,p.71) argued that:

"The initial development of friendship depends above all upon opportunity. Friends are usually subject to the constraints imposed by their family, occupational and social background."

The value or reward of a friendship to an individual in community care depends on the capacity of others to provide certain services such as emotional support, information and

resources outside one's immediate network(Willmott,1986, p.36). Willmott(1986) argues that a number of studies show that friends are relatively unimportant as a source of social care(p.71). Unlike primary kin ties they normally do not endure when circumstances alter and the majority of friendships are usually defined as being about sociability rather than caring as such(Abrams,1984, pp.427-428).
As shown in discussion above, the community serves as both 'the provider as well as the recipient' of social service. Even informal relationships of one kind or another decline with social change, so the concept of social network is particular useful for the analysis and understanding of local level informal social ties(Bulmer,1993,p.235). Given these different functions in each social network, it is suggested that as sources of a social care network, kinship, neighbours, and friends tend to meet different types of need, rather than substitute for one another in community care.

## The ideological, political, and economic contexts of community care

The discussion so far has concentrated upon the sociological contexts of community care. Before proceeding with analyses of the ideological, political, and economic contexts of community care, some questions posed by Walker(1987,p.370) may help to focus the presentation.

"Why has interest in community care mushroomed in recent years for the policy makers ? Why has community care been offered as the answer to some problems associated with state welfare ? What norms and values underlay this relatively new policy ?"

These questions are at the heart of the ideological, political and economic contexts of community care.

Walker(1987) makes one possible answer to these:

"Recent challenge to the related growth in interest in the community care may be traced to two factors; the one, there is the fiscal crisis of the mid-1970s and the ideological and policy changes following. The other, there are various specific criticisms of state social services which have evolved over the last 30 years. The former often aims at replacing public social services with private ones or a combination of financial stringency and increasing demands for resources to search for alternatives to state public services. The latter is concerned primarily with making public services more responsive to the informal sector"(pp.370-371).

In this section, three contexts of community care are identified. It begins with the ideological context focused on the New Right, followed by an account of political and economic contexts being mainly established during the 1980s.

*The ideological context*

The role of the state in economic and social affairs has always been 'an ideologically contested issue particularly since the introduction of democratic forms of government'. A host of economic, social and political factors intervene to shape particular policy proposals into what government considers possible at any one time((George & Wilding, 1994,p.1). Relating this to the development of community care, one can say that ideology has played a part in the development of community care.

The evolution of the liberal welfare state was based on post-war economic prosperity. Sustained growth and near full employment during the 1950s and 1960s delivered a welfare surplus, which provided for the massive expansion in social expenditure(Walker,1987,p.371). However, there was the fiscal crisis of the mid-1970s and in the wake of economic change came ideological and political changes. In particular there

existed the 'signs of trouble' referred to by Mishra, including loss of confidence in the welfare state. Alternative political theories were, therefore, more likely to be seriously accepted and examined in the political forum than had been the case in the 1950 and 1960s. Perhaps the most obvious and successful of these had been the New Right (Bochel,1991,p.12), which was essentially to take up, develop and extend classical liberal critiques of state action and applied them to the key issues of economic and social policy (George & Wilding,1994,p.15). It posed the supremacy of the market and the need to reduce the role of the state. The welfare state has been one of the major foci of the New Rights attacks for a variety of reasons. One is that 'it is seen by some as placing too great a burden upon public expenditure' (Minford,1984;Bochel,1991,p.14). Another reason is that the concept of choice is critical in the idea of the New Right, and according to its spokespeople the welfare state negates choice, while the private market promotes it (Harris & Seldom,1979;Bochel,1991,p.14). George & Wilding(1994) examined the New Right's attitude to the welfare state under several headings: 'the impossibility of creating a comprehensive welfare state'; 'mistaken views of human nature and social order'; 'mistaken ideas about welfare'; 'the welfare state as a threat to freedom; inefficient and ineffective'; 'as economically, socially, politically demanding'(pp.21-35).

The arguments of the New Right have been countered in a variety of fields. In thinking of community care under the New Right, the main thrust of policy has been towards reducing the role of local authorities as service providers while encouraging the growth of informal, voluntary and

private welfare, often under the guise of promoting a 'mixed economy of welfare'. Therefore, the ideology of community care may be regarded as a specific illustration of four of the main manifestations of the neo-liberal philosophy (Walker,1989,p.204):

"Antagonism towards public expenditure on the welfare state (Walker,1982), increasing emphasis on self-help and family support(Wilson,1982), extension of the market and commodification of social relations(Offe, 1984), and the general breakdown of the social democratic consensus(Gamble, 1987)".

*The political context*

As mentioned earlier, new ideologically inspired pressures arising in the late 1970s and early 1980s - budgetary and resource constraints and the cost-effectiveness imperative - combined with a major expansion of need for care, particularly among very elderly people, produced the political will to overcome both inertia and sectional interests. The emphasis in policy has shifted away from care in the community by local authority personnel towards an even more confusing mixture of care by the residualised social services and promoting the private sector(Walker,1989, p.207).

One of the most distinctive new policies which came to symbolize the determination of Mrs. Thatcher's Government under the New Right to reverse the settlement of the 1940s was privatization. Soon after coming to power, the DHSS moved to encourage a switch in the provision of residential care from the public sector to the private sector(Walker,1989, p.207). The introduction of privatization in social services, according to Lewis(1994), has been described by Le

Grand(1991) as a response to critics on both the political Right and the Left:

"Critics on the Right had charged that welfare bureaucracies were wasting resources on excessive administration and that they offered the client little choice in services and hence were not meeting clients' needs. Critics on the left were concerned with equity as well as efficiency"(p.158).

In what ways might services be privatized, and to what extent might this be applied to community care ? Le Grand and Robinson(1984) identify three broad areas of state intervention - reducing state provision, the sale of old person's homes and mental hospitals and so far as community care is seen as anti-institution, reducing state subsidy which can take two forms - increased charges for consumers and reduced payments for service contractors and reducing state regulation which can promote competition (Hudson,1990, pp.17-19). Changes in the social security system in 1981 and 1983 effectively gave an open-ended grant to those entering private or voluntary homes, resulting in an enormous(138%) rise in the number of private residential beds(Lewis, 1994, p.150). This was most clearly reflected in the growth of expenditure on private residential homes, which increased from £10 million in 1979 to over £1,000 million in 1989 (Hudson,1990,p.24).

Secondly, community care was predominantly concerned to revalue and integrate dependent people into society (Heginbotham,1990,p.48). In other words, it meant about how services could reflect the basic right of dependent people in an egalitarian society. Community care should be viewed in conjunction with normalisation, which was 'a broader political perspective of the care, support and treatment needed by people requiring long-term care'(Heginbotham,

1990,p.49). Normalisation was initially a straightforward concept which emphasised that services should attempt to deliver a high quality of life for users and that this required them to reproduce the life style experienced by non-disabled citizens through such characteristics as the rhythm of the day, progression through the life course, self-determination and economic standards (Means & Smith,1994,p.73). The general aim of community care policies were stated by DHSS(1981), *Care in Action:*

"to maintain a person's link with family and friends and normal life, and to offer the support that meets his/her particular needs"(DHSS;Walker,1989,p.211).

Many elderly people do not require specialist services and are able to live independently. As a person becomes very elderly or frail, additional help may be needed for them to live on in their own home. Those who do not ask for specialist services encourage social theorists to appeal to hidden non-institutional care as enabling citizens to lead more normal lives in the community. Strengthened primary and community care services help elderly people to live independently in their own homes, 'including in some cases residential, day care and support which enables them to keep in touch with their normal lives'(DHSS,1981b,p.1). It should be recalled that normalisation theory was a major factor in persuading policy makers and professionals to reject hospital-based services in the UK(King's Fund Centre, 1980;Means & Smith,1994,p.73). The policy of hospital rundown dates back to the hospital plan of 1962. However, prior to 1987 no major hospital had been closed(Social Services Committee,1982; Walker,1989, p.211). But the decline accelerated in the 1980s as the Government's discharge

programme took effect. For example, in the ten years to 1986 the average number of daily occupied beds in mental illness hospitals fell from 109,000 to 82,500(Walker,1989, p.211). Thirdly, community care has firmly located residualising the services at its hub(Parker,1985;Wicks, 1987,p.119). It was a policy around which there appears to stand a remarkable political consensus: the role of the immediate 'community' of family, friends and neighbours had been stressed increasingly(Wicks,1987,p.119). In 1980, according Walker (1989), the Secretary of State, Patrick Jenkin, outlined a supportive and decidedly residual role for the social services. He had justified the cuts in personal social service expenditure and the closure of long-stay hospitals on the assumption that the non-formal sector would expand:

"In personal social services there is a substantial possibility and, indeed, probability of continuing growth in the amount of voluntary care, of neighbourhood care, of self help"(Social Services Committee,1980,Walker,1989, p.213).

The White Paper(DHSS,1981a), *Growing older*, also asserted,

"Whatever level of public expenditure proves practicable, and however it is distributed, the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship, and neighbourhood ....Care in the community must increasingly mean care by the community"(p.3).

The performance of such caring functions was crucial to the operation of community-based care and to the government's estimation of its cost effectiveness. In 1984 Norman Fowler, Secretary of State, provided the clearest and most detailed outline of the new residual role proposed for social services in a speech to the Social Services Conference. According to Walker(1993), he argued that 'the fundamental role of the state to back up and develop the assistance which was given

by the private and voluntary support'(p.213). The Audit Commission(1986), *making a reality of community care,* came to the same conclusion:

"Joint planning and community care policies are in some disarray. The result of poor value for money. Too many people are cared for in settings costing over £200 a week when they would receive a more appropriate care in the community at a total cost to public funds of £100-130 a week. Conversely, people in the community may not be getting the support they need"(p.3).

Whatever romantic images the phrase 'community' conveys, some research evidence has consistently found that the reality of community care is largely care by families, specially women (Wicks,1987,p.120). In a national study of informal carers, the survey suggests that the majority of female carers(over 70%) are caring for relatives(Green,1988;Graham, 1993,p.125). However, several trends challenge caring work by women in community care: an increase in women's employment increasingly questions women's 'cultural designination as carers'. When a women is at the same time caring for a husband and children and managing two household or regimes, the burdens are enormous. This is the unromantic, uncomfortable reality of a great deal of caring work: hard manual labour, sleepless nights, and mental stress (Walker,1987,p.377). Community care is clearly a key issue for women. The women's movement argues that community care is a euphemism for care by female kin (Wicks,1982,p.106).

*The economic context*

At the same time as resource constraints have been imposed on community care, the additional source of pressure - demographic and social factors on resources have exacerbated

their impact and deepened the dilemma facing policy-makers, including those seeking to maintain welfare expenditure at a time of low growth and reduced economic activity (Walker, 1987,p.373). Between 1976 and 1991, the numbers of those aged 75+ in England and Wales increased from 2,546m to 3,232m, and the numbers will increase to an estimated 3,302m in the year 2001(see table 3-2 in chapter three). It is among the elderly people groups that the greatest need and, therefore, the main demand for social services expenditure occurs. When the financial costs of informal care and quasi-formal care are compared with those of formal care, the attractiveness to policy makers of substituting the former for the latter is obvious. According to Tinker's research, among elderly people judged to be in the 'high dependency' category, the costs of providing paid neighbourly helpers and home care assistants in 1981-1982 were, respectively, 21 % and 23% of the cost of an acute hospital bed, 29% and 32% of the cost of a geriatric hospital bed, and 71 % and 79% of the cost of a place in a local authority Old People's Home(p.112;Walker,1987,P.374). The Audit Commission(1986) evidently regarded community care as being cheaper than residential care. It calculated that the care of a frail elderly person cost the state only £ 135 per week in a domiciliary setting, but £ 295 per week in a NHS geriatric ward(Lewis,1994,p.150). In response to the debate following the Audit Commission report(1986), the Griffiths report(1988) inquiry examined problems in the arrangements for community care and published its findings. The report proposed the use of care management to ensure a more effective use of resources in community care(see section one in chapter three). It has recently been reported that care management in community care has been achieved at no

greater cost than conventional services delivery, including improved efficiency in care provision (Challis et al.,1993, p.200). Discussion related to care management is presented in the next section.

## Implications of concepts of community and community care for community care in Korea

We have discussed sociological concepts of community, ideological, political, and economical contexts as they have affected the development of community care in the UK. Communities as types have played a significant role in explaining the direction of social change in a society, especially in the distinction between tradition and modernity, although, according to Gusfield(1975), 'the crux of the difficulty is the mixed character of the concepts as referents to the real world'(p.79). The paradigm is also regarded as the most suitable sociological explanation of changing Korean society. According to Choi(1985), rural community is still characterised by Gemeinschaft based upon the family and traditional community ties. On the other hand, urban life is dominated by Gesellschaft, representing individualism and contractualism(p.13). In traditional Korean society, the clan(blood relatives) within a geographical area was the most basic unit for building up a community. The community had the crucial quality of communal interaction which represented strong kinship and solidarity under Confucian morality(see section one in chapter four). Family care for elderly people was the most prevalent way within a more than three generation family without any state or voluntary service involvement.

However, there has been change in the main role of a

community in the process of modernisation and industrialisation. Land reform of 1950 and the Korean war were the most critical factors among social events by the end of the 1950s(see chapter one). The structure of the clan as a community was broken up and the cohesive power of the clan as a community weakened(Chang,1993,pp.157-158). This does not mean the clan-oriented community totally diminished. It still exists in rural areas but involves a different composition of clan in a community. Community converted its active mechanism from the clan-oriented structure to an individual family-oriented one through the land reform and Korean war. Since the early 1960s, as discussed in chapter one, industrialisation has led to inter-regional migration as people, mainly the young generation, sought jobs in the cities. As a result of this, the network concept, especially in the urban areas, plays the main role in interpreting community. It is quite explicit that formal and informal networks, i.e. largely non-institutional relationships, are at the heart of community in urban life in Korea. A network community, which allows a wider range of relationships, tends increasingly to expand in Korea. Network community stemmed from modernisation and industrialisation as these resulted in social change, especially the disintegration of traditional forms of family structure.

Therefore, community care for elderly people in Korea has developed through people coping with social needs created by the rapid social change(see section one in chapter four). Unlike Western countries, community care for elderly people in Korea has progressed from traditional family care to care in a community. It means that informal care has become heavily dominant, and state and voluntary services have

increasingly provided for the care of elderly people. State and voluntary services are provided by an administrative organisation, with community centres, and welfare centres within an administrative locality. However, community care means very different things to different persons and places. From the UK experience, community care for elderly people refers to policy requirements, the management of services and delivery of services. Therefore, the present writer can operationally suggest the following definition of community care for elderly people in Korea:

Community care is to provide appropriate services by the mixed economy of care in order to reduce the burden of family care(carers) and enable elderly people to stay in their home independently; to provide appropriate services to meet the needs of elderly people and carers within an administrative locality.

## CARE MANAGEMENT

The purpose of this section is to examine the concepts and models of care management, including their possible relevance to developments in community care in Korea. Care management has been conceived as the means for the effective implementation of community care, particularly for elderly people. However, there is some disagreement over the term 'care management'. Some call it care management, but others call it case management. The first subsection discusses the origins of care management to identify a suitable definition of this term. In the second subsection, concepts of needs in relation to care management are discussed. The literature on needs is mainly western. It may not equally be applicable to Korea. Needs in relevance to community care for elderly people in Korea is discussed at the end of this section. In the third section, models of care management are considered, reflecting the actual practice of care management with diverse group of clients. Before implications of care management for community care for elderly people, the summary table on care management models is given(see table 2-1). This concerns the particular application of each model to Korea, particularly whether it might be suitable for either urban or rural settings. Feasibility of care management models in Korea is then considered in the following subsection.

### Concepts in care management

How may we define care management for the long-term care clients ? Is it a clinical service ? Is it a administrative approach ? Does it consist of brokering, of treatment, or of

some combination of these functions ? In considering the concept of care management, we often face two problems. First, the term is frequently used in the absence of precise definition, so that its meaning is fuzzy. Second, even when clear and operational definitions are offered, they are at great variance - so much so that one may well wonder why such different entities have been given the same name(Bachrach, 1989,p.883).

*Origin*

In the UK there has been a long-standing concern to improve co-ordination in the development of community care policy, going back to two important policy developments: the 1959 Mental Health Act and the 1963 policy document, *The development of community care*(Challis et al.,1995,p.19). During the 1970s, in the newly developing post-Seebohm personal social services, attempts to improve interagency co-ordination between health and social care principally took the form of initiatives such as joint care planning and joint financing(Sinclair et al.,1990;Challis et al.,1995, p.19).However, case management first surfaced in the UK towards the end of 1970s. The American concept of case management was imported into the UK through the crucial agency of the PSSRU at the University of Kent in its work first on the Kent Community Care scheme (Payne,1995,p.57). American case management(see the following section on international studies on care management) has developed in the context of American social services where hospitals, community care and social work agencies have been typically relatively uncoordinated, independent institutions(Payne,1995 ,p.52). The problems were compounded by the rapid expansion

of categorical arrangements in social and health services in the 1960s. Delivery systems became an even more complex, fragmented array of separate programs, with many of the most needy 'falling through the cracks'(Rothman, 1992,p.3). Another element was a preoccupation with accountability and cost-effectiveness in service delivery(Weil,1985;Rothman, 1992,p.3). American case management makes more of the brokerage and advocacy roles open to the case manager. However, the British experiments have put most emphasis on care management as a mechanism for linking and coordinating (Challis,1994;Lewis & Glennerster,1996,p.120).
The Griffiths Report(1988) officially provides the seed of the idea of care management in the UK. It saw a role for local authorities in organising community care, but also introduced the notion that they could design and purchase, rather than be direct providers of services. These proposals were relatively quickly translated first into a White Paper(1989),*Caring for People*, and then into legislation, the NHS and Community Care Act 1990(Orme & Glastonbury,1993,p.2). The Department of Health published the Practitioners'(1991b) and Managers'(1991a) Guide of Care management and Assessment to further define the roles and tasks of the care manager.

*Definitions*

Before proceeding with a definition of care management reflecting its development in the UK, it is sensible to clarify the application of the terms 'care management' and 'case management'. Initially the term 'case management' used in USA was also used in the UK with those performing case management tasks called 'case managers'. However, some writers in this field began referring to 'care management'

not 'case management'. The former was employed in the Griffiths Report(1988) and the latter in the White Paper (1989). Some authors proposed definitions differentiating the two titles; 'care management being the client based work and care management existing on the stage higher in the management hierarchy as the management of the case management'(DoH,1991;Challis et al,1995, p.18). Later the Department of Health(1991a & b) guidelines published for managers and practitioners referred to care management, 'justifying this in terms of the fact that it is the care which is being managed and that the word case may be perceived as demeaning'(Challis et al,1995, p.18).
According to Orme & Glastonbury(1993), the use of care management is significant because:

"it is an acknowledgement that the work which will need to be done to ensure care in the community is not merely with an individual case, client or person but can involve the provision of a range of activities and services provided from a variety of sources"(p.3).

However, Onyett argues against the use of the term care management on the grounds that:

"the term 'care' obscures the need to focus on needs and strengths of individual users; implies a passive relationship between users and providers; and can be equated with being banished from everyday life"(Onyett,1992; Huxley,1993,p.367).

It is, nevertheless, important to remember that case management is the term prevailing for the same process in North America and in much of the UK literature through the 1980s. In this thesis we refer to use the term 'care management'.
A number of definitions of care management have been put forward in the UK. The definition of care management is far from easy: definitions abound and even terminology changes

(Challis et al. 1995,p.18); case coordination, continuing care coordination, service integration, service coordination, geriatric consultation, utilization review, preadmission screening, discharge planning, and so on(Parker et al.,1992, p.54). The Social Service Inspectorate's Practice Guides (DoH,1991b) stated that:

"Care management and assessment constitute one integrated process for identifying and addressing the needs of individuals within available resources recognising that these needs are unique to the individuals concerned. For this reason care management and assessment emphasise adopting services to needs rather than fitting people into existing services and dealing with the needs of individuals as a whole rather than assessing needs separated for different services"(p.9).

Another official definition given by DoH(1994) is that:

"Care management is the process of tailoring services to meet the individuals'needs identified in the assessment. This is a continuing process involving users and carers which ensures that services are appropriate and flexible and is responsive to their changing needs. Users and carers can expect to receive services as part of a co-ordinated package of care which may include services provided by other agencies"(p.7)

The basic characteristics of care management are implied by definitions mentioned above, such as empowerment and consumer choice, the mixed economy of care, cost effectiveness by matching resources to needs, improving accountability, improving quality of services, and a needs-led approach.

## Needs and care management

According to Sheppard(1995), needs are widely regarded as fundamental to the welfare services(p.117) and 'absolutely central to official versions of care management'(p.5). As mentioned earlier in a definition of care management, care

management emphasises adapting service to clients' needs rather than fitting service-users into existing services. However, the concept of needs has received little systematic attention in the theoretical literature of social policy, including care management in community care. Richard has neatly summarised the reason:

"Separating the assessment of needs from a subsequent decision about eligibility depends on in fact on the concept of needs being operationalised independently of the agency policy and guidelines are to determine what is to count as need, and that is where the difficulty lies"(Richard,1994;Lewis & Glennerster, 1996,p.152).

Williams (1974) also has argued the problem:

"The word 'needs' ought to be banished from discussion of public policy, partly because of its ambiguity, but also because..The word is frequently used in..arbitrary sense...in many public discussions"(p.67).

Needs is regarded as a complex, arbitrary, and ambiguous concept which can be defined in various ways. Therefore, With respect to this difficulty, the Practitioners' Guide (DoH,1991b) analysed the characteristics of needs as a dynamic, relative, multi-faceted, personal, and complex concept. The Guide defined needs as follows:

"the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life, as defined by the particular care agency or authority"(p.12).

Several concepts of needs, such as basic, social, relative, and objective needs, are implied by the definition mentioned above.

*Basic and social needs*

Basic needs is 'a controversial concept which depends on the time, place, and social and culture circumstances'. Historical debates over whether the living standard has risen or fallen, or World Bank debates over what exactly the 'basic needs' strategy would require for any given country, clearly must take such relativization of the notion of basic need very much to heart(Goodin, 1990,p.14). The most well-known typology of basic needs was formulated in 1954 by Maslow: psychological, safety, love, esteem, and actualisation needs (Doyal & Gough,1991,p.35). On the other hand, Doyal & Gough(1991) argue that 'two basic central components of basic needs are survival and autonomy. These are the preconditions for any act at all by an individual in any culture'(p.54). Sheppard(1995) argues that

"Survival and autonomy must be satisfied to some degree before individuals can effectively participate in any form of life, and carry out successfully their life plans for the avoidance of serious harm"(p.128).

In relation to the formulation of social policy, Harris sums up the consequences of basic needs:

"Social policies should be directed toward guaranteeing a range of life chances to the citizens of a society. The relevant life chances are those required to protect the status of individuals as full members of community....Needs, by implication, are defined as whatever is necessary to that end. An individual is in need for the purposes of social policy to the extent that he lacks the resources to participate as a full member of society in its way of life"(Harris,1987;Doyal & Gough,1991,p.52).

Basic needs are always going to be interpreted in a particular society and thus in a sense are going to be relative to social needs. The concept of social needs is 'inherent in the idea of social service. The history of the

social services is the story of the recognition of social needs and the organisation of society to meet them' (Bradshaw,1972, p.640). Social needs are demands which have been defined by society as sufficiently important to qualify for social recognition as goods or service which should be met by government intervention (Nevitt,1977; Doyal & Gough, 1991, p.10). Therefore, as Sheppard(1995) argues, to consider that 'social need can be defined objectively assumes a high degree of consensus: a broad acceptance of the general framework of a society's structure'(p.130). It means that social needs are defined by a government/local authority, administrative experts. This approach link to the issue of rationality, autonomy, participation, and self determination. The second approach involves a distinction between felt and attributed needs with wants(p.131). Felt need turns into action, expressing needs which are commonly used in the health services where waiting lists are taken as a measure of unmet needs(Bradshaw, 1972,p.641). This approach allows consumers for involving them in the creation of agency definitions of need(Sheppard, 1995, p.132). In community care for elderly people this would involve the views of service users rather than those of social workers. This is consistent, in fact, with the approach of care management in community care(Sheppard, 1995,p.129).

*Objective and relative needs*

According to Miller(1976,p.129), 'an objective approach helps obviously to define what is distinctive about needs'. He states differences between needs and wants which are also described as goals(objectives) but which derive from an individual's particular preference and cultural environment

(Doyal & Gough,1991,p.39):

"Wanting is a psychological state ascribed on the basis of a person's avowals and his behaviour..Needing, on the other hand, is not a psychological state, but rather a condition which is ascribed 'objectively' to the person who is the subject" (Miller,1976,p.129).

Some evidence of the objective approach is shown in official documents on care management, the Practitioners' Guide: 'a need-led approach requires need to be explicitly defined and prioritised in policy statements'(DoH,1991b,p.12). According to Sheppard(1995), need is divided into 'six broad categories, each of which should be covered in a comprehensive assessment: personal/social care, health care, accommodation, finance, education/ employment/leisure and transport/access'(p.118). On the basis of the needs-based assessment, the care manager is required to prioritise, for example loss of independence, clients' level of need. However, there is little room for more flexible qualitative assessments of need by a care manager. It is implied that needs provides the definition of the objectives of the services(Sheppard,1995,p.118). Therefore, Forder(1974,p.39) argued that the definition of need present a central problem for social services. An objective conception of need does not adequately cover need as expounded in care management. There is, in certain sections of official documents, clear evidence of a relative sense. Needs is 'a dynamic concept, the definitions of which will vary over time in accordance with changes in national legislation, changes in local policy, the availability of resources, the patterns of local demand'(DoH,1991b,p.12) and a relative concept:

"No two individuals will perceive or define their needs in exactly the same way. Care management seeks to recognised the individuality of needs by challenging practitioners to identify the unique characteristics of each individual's needs"(p.13).

However, for needs-satisfaction, which strategy we should ultimately prefer depends on what alternative mechanisms are available for satisfying relative needs, and on how effective they happen to be(Goodin,1990,p.17). More specifically, the best way of satisfying unmet needs may not be to cause those who are relatively more needy to have more of the needed resource, but rather to cause others to have less of it. Most fundamentally, perhaps, we can see needs as always being relative to the goals for which the resource in question is needed. Needs is inherently instrumental in the respect of political as well as philosophical, and as mentioned earlier, needs have been identified in areas of personal and social life closely related to perceptions of needs(Goodin,1990, pp.12-13). Therefore, policy should be guided by principle, equalization rather than maximization of resources that are needed in this relative way(Goodin,1990,p.28).

To sum up, social services are closely related with the recognition of people's needs in the process of developing social policy. However, John Baldock(1994) has argued that 'needs has historically been a small consideration in the scale and scope of the personal services'(p.162). Indeed, the emphasis on providing services responsive to needs came squarely into conflict with the government's desire to limit public expenditure. Therefore, the idea of needs as a determinant of rights to services has always been criticized. New Right theorists have tended to dismiss the idea of needs as inherently paternalistic. They see a contest between the increased demands on social services and limited resources in care management in community care. The needs of carers and users may be pitted against one another as well as being contested by the authorities(Lewis, 1997, p.15).

## The models of care management

Within the basic care management framework, there are a hug number of care management models(Renshaw et al.,1988, p.101). Typically, they can be classified according to target population, auspice, purpose, setting, roles performed (Netting,1992,p.161), location and nature of tasks, type of worker employed, and the scope and influence of care management function(Renshaw et al.,1988,p.101). The choice of care management model often appears to be determined by expedience - to make best use of the available resources and existing system while attempting to meet the client's needs(Renshaw et al.,1988,p.111). However, it is not always clear what the specific active ingredients are in any one approach. It is also not clear where particular care management approaches are related differentially to the quality of life or satisfaction of the service user(Huxley & Warner,1992,p.799).

This section seeks to assess the value of care management models in relation to organization, inter-agency, locality, and primary content and arrive at a view of their value in different settings. The study may provide information about a care management most suitable model(s)in community care for elderly people in Korea.

### *Organizational models*

#### Generalist model

The model stresses coherence and accountability in the delivery of services to the clients(Roberts-DeGennaro,

1993,p.106). A care manager must take responsibility for the coordination of services while at the same time acting as the individual's guide and helper(Renshaw et al.,1988,p.97). Wiltse and Linda support this model:

"It is a misconception to think that the care manager's role is limited to only brokering services or that direct practice is not a feature of care management"(Wiltse & Linda,1982; Roberts-DeGennaro,1987, p.467).

The balance of duties she/he should undertake, the scope of his/her responsibilities, qualifications, status and management present difficulties in this model(Renshaw et al., 1988,p.102). Rothman(1992) notes a disadvantage to using a generalist approach to care management in that 'it may be taxing for a practitioner to take full responsibility for the diverse elements of any given case, if many cases are assigned to the practitioner'(Roberts-DeGennaro, 1993,106). Care managers may also spend a great deal of their time processing paperwork or communicating with other service providers, because the care manager's role is to assist clients by helping them deal with any or all of these system problems. In this model short-term task-centred work is emphasised rather than providing long-term therapy or treatment. The generalist model of care management, therefore, focuses on helping clients identify and resolve concrete problems in their every day lives(Roberts-DeGennaro,1987, p.468). Only in social services in which the administrators understand the functions performed by care managers will there be an effective and efficient care management practice model in operation (Roberts-DeGennaro, 1993, p.107).

**Clinical model**

Clinical care management is defined by Kanter(1989) as:

"A modality of mental health practice that, in coordination with the traditional psychiatric focus on biological and psychological functioning, addresses the overall maintenance of the mentally ill person's physical and social environment with the goals of facilitating his/her physical survival, personal growth, community participation, and recovery from or adaption to mental illness"(P.361).

The central features of the clinical model of care management is that there is a recognition that the care manager is providing important aspects of care for the clients. The worker is seen as an important resource, there is an awareness that the process of assessment and reassessment is a crucial function, to be discharged by someone who knows the client really well over a long period of time (Huxley,1993, p.372). Kanter(1989) proceeds to describe a persuasive model of clinical care management which manages to effectively span the continuum of brokerage at one end and highly therapeutic care management at the other. He argues that 'care management is a specialised role in mental health settings and cannot be seen as merely an administrative system for coordinating resources'(p.107). A clinical model of care management would seem to be a helpful counter to the risk of bureaucratization and insensitivity in the new care arrangement(Challis,1994, p.107). Kanter(1989) also argues that the clinical model of care management requires a professional level of skill and competence(p.361). Shepherd(1990) supports the view that the care manager in a clinical approach might be recruited from relatively experienced, highly trained clinicians(p.60).

**Administrative model**

The essential feature of the administrative model is that the functions of assessment and provision are separated from one another(Huxley,1993,p.373) and where service arrangement and coordination are seen as the central tasks (Challis,1990, p.15)(see role of care managers in chapter three). The separation of assessment from provision is seen by many people involved in the community care reforms as the way to achieve the movement from a service-led to a needs-led approach. The care manager relies heavily on linkage and brokerage(Huxley,1993,p.373). The model may only be appropriate for users with a range of simple, practical needs rather than any emotional or psychological needs(DoH,1991a, p.74). There is some limited evidence that the administrative model might be more suited to the needs of people with a physical disability(Pilling,1988; Huxley,1993, p.373), whereas people with mental illness may find the administrative model unacceptable and less effective(Huxley & Warner,1992, p.802).

This approach has produced some advantages. Firstly, it is efficient in respect to coordination and clear accountability. Secondly, professional staff may be released from administration(DoH,1991a,p.73). The great danger of the administrative model would appear to be how it fits perhaps too easily into existing structures and patterns, permitting an unnecessary and probably undesirable separation of responses to the practical needs of individuals from their psychological needs(Kubisa,1990;Challis,1990,p.15). Huxley (1993) also argues that the identification and recording of unmet need is not a finding which agencies or government will

want to be made public, even though the workforce undertaking the assessment will have been expensively trained as professional providers(p.373).

**Decentralized budgetary control model**

Huxley(1993) argues that 'the issue of the decentralization of services to local bases in the community has inevitably brought with it questions of the decentralization of budgets'(p.373). In community care, the purchasers/providers split is understood as both a macro-budgetary strategy in which both health and social service are divided into purchasing and providing organizations; and a micro-budgetary mechanism for decentralizing resources into front-line workers and managers in order to more effectively target these resource on those identified as most in need by the care management assessment(Huxley,1993,p.373). The separation of purchasers and providers is seen as an important part of the development of services in the UK with care management seen as a purchaser role(DoH,1990;Challis,1994,p.105). Challis and Davies(1986) describe the purpose of the devolved budgets as an 'incentive for improved assessment, to make possible more creative responses.....and taking advantage of local circumstance'(p.9). The advantage of devolved or individualised budgets is that they convey clear financial signals, which ease the task of allocating resources or facilitate service purchasing across the mixed economy. They also increase the range of opportunities for service substitution, and are more likely to result in service flexibility, efficiency and equity. On the other hand, detailed and accurate cost information is essential, which

is itself costly to obtain and maintain(Cambridge, 1992, p.509). Budgetary delegation to care managers helps to overcome the tendency for macro-organization to determine service packages through set mainstream services. In micro-budgeting, for example, Maidstone linked user budgets to two-thirds of the cost of hospital care, and care managers had to shadow services costs and bought in a range of supplementary services, encouraging cost-effectiveness and accountability(Cambridge, 1992,p.514). However, according to Cnaan (1994,p.547), Kanter(1989) argues that such a devolved budgets control is virtually non-existent without education, experience, high salary or professional status.

*Inter-agency models*

**Single agency and joint agency model**

The design and operation of care management is influenced not only by local service management but also by funding, and the extent and style of inter-agency working (Cambridge,1992, p.512)(see role of care managers in chapter three). So, models of care management have been developed that involve various combinations of agencies in different relationships with one another(DoH,1991a,p.75). 'The eventual goal of inter-agency arrangements may be a unified management of schemes with resources pooled in a common budget from which all staffs may draw'(DoH,1991a,p.78).

In a single agency model, there is a clear advantage in the accountability of the agency, in less development time being required, and reduced negotiation and consultation. However, the risk of services becoming anachronistic, by a narrow

definition of services, and less incentive to innovate are identified as disadvantages by the DoH(1991a). In the Kent and Gateshead schemes(see discussion on UK vare management projects in chapter three), for instance, the models of care management were based on single agency, the social services department. A care manager was limited by direct access only to the resources of the social service department. Another disadvantage was in the lack of important health staff inputs required to achieve the objectives effectively. Whereas the advantages of the models were the relatively low amount of organisational upheaval and management effort required to establish and maintain such a system. It is clear that effective long-term care of the clients, specially elderly people, require health and social care inputs to be combined. (Challis, 1990,p.14).

In a joint model, the advantages are: a holistic response to needs on an across agency basis; access to a range of skills for users and more cost-effective resource usage, promoting the creation of multi-purpose workers; and shared management accountability for agencies. However, the disadvantages are: risk of inter-agency collusion disabling users; inter-professional rivalries; and the problem of creating pooled resources(DoH,1991a,p.76). The Griffith report(1988) mentioned some difficulties of a joint service if only through its implicit separation of responsibility and therefore budgetary accountability for acute and chronic care between NHS and social services(p.15). Meuller and Hopp also argued problems of a inter-agency model: it is clear the suspicion and rivalry which often characteristics the relationship between caring agencies could make them worse(Meuller & Hopp,1987; Shepherd,1990, p.60)



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*Locality models*

**Rural and urban models**

Krout(1993) has pointed out that 'care management in rural areas clearly involves different definitions and applications and is found in diverse forms nationwide' (p.144). Compared with urban clients, there are a number of problems in providing a care management service to rural clients. These problems can centre on the lack of available and accessible services, financial constraint, staffing issues, and constraints on delivering services (Parker et al., 1992,p.55) by limited transportation and greater geographic distance (Cordes, 1989;McConnel & Zetzman,1993; Shelton et al.,1994, p.99). Foster et al.(1994) argue also that the greater challenge to coordination is posed in rural areas, where not all services may be available in the same community and where the clients needing services do not live in close proximity to the delivery site(p.14). Rural care managers have to deliver a range of services themselves which would be otherwise available from other agencies and workers in an urban setting(Renshaw et al.,1988,p.103). Rural care management difficulties also reflect what some see as an urban bias in program funding and regulations/ legislations in health care, and the tendency on the part of policy makers to view "scaled-down" urban models as the appropriate response to rural realities(Coward,1979; Krout,1986; Krout, 1993,p.138). Busby describes a nursing agenda for rural health issues, encouraging a range of methodologies for health care delivery, including care management strategies (Busby, 1992;Krout, 1993,p.138). Most often rural care-

managed clients are elderly people. They tend to be hardy individuals, extremely independent, with less formal education than urban residents. It means care management becomes a sensitive issue when dealing with rural clients. Not only is it difficult to find referred clients in order to make initial contact, but care managers may have problems in providing consistent follow-up care, and monitoring the clients progress(Parker et al., 1992,p.55).

There are several important differences between rural and urban care managers. Rural care managers tend to be less specialized than those in urban areas. Likewise those in rural areas serve clients of all ages with a wide variety of diagnoses, while those in urban areas often specialise in one age group or problem, such as geriatrics and paediatrics, psychiatric(Parker et al., 1992,p.56). Rural care managers may not have access to formal services , but they are in a position to coordinate informal support services. Generally speaking, rural care management needs to develop more options for community based services(Parker et al.,1992, p.75).

*Primary content models*

**Social skills training/assertive outreach model**

Care managers are encouraged to be flexible, in order to respond to the varying needs of their clients and to develop appropriate and possibly imaginative combinations of services. They should appreciate that clients need to build on their own strengths and reach as great a degree of independence as possible(Renshaw et al.,1988,p.98).

Care management in 'rehabilitation work with these clients

involves specific(intense) components', such as skill training, medication review, assertive outreach, 24 hours coverage, which may not be seen in other forms of care management (Huxley,1993,p.371). Psychiatric rehabilitation services have attended to the needs of people who are unmotivated and resistant to help, and various models of psychosocial rehabilitation have been developed as a consequence. These models involve training users in skills needed for community survival, including medication management(Eckman & Liberman,1990;Huxley,1993,p.371) and attention has focused on people with long-term needs, and involving them more closely in assessment and selection of goals(Liberman et al.,1987; Shepherd,1990; Huxley,1993, 371). All patients are assigned to a care manger or to a core service team that undertakes care management functions. Care management was thus perceived as both an individual role and, with the most difficult and demanding patients, as a team responsibility. Associated with the organisational principles were a set of core clinical principles. These included assertive outreach, individually tailored programmes of care, ongoing monitoring, titration of levels of supporting according to needs, training and support in patients'family environments, building upon patients' strengths, treating them as responsible citizens, and provision of crisis intervention(Stein,Diamond & Factor,1989;Challis, 1994, p.101).

**Brokerage/Advocacy model**

Care management is a brokerage/advocacy service(see role of care managers in chapter three) 'that attempts to integrate

the long-term care system with the caregiving provided informally by family members, friends and community groups' (Capitman, et al.,1986; Fisher,1990,p.211). In the brokerage /advocacy model of care management, the protection of individual rights, working on behalf of the client for more and better services, attempting to ensure that existing services meet client needs and provide care to agreed service specifications, are all emphasized. The provider's role is not emphasized in the brokerage model which involves ensuring that others provide the needed services (Huxley, 1993,p.371). The care manager coordinates 'the inputs of several different services, provides consistency and commitment, and acts as advocate on behalf of the clients to make certain that they receive the appropriate package of services'(Shepherd,1990, p.59).

The model has been presented by a number of authors. Lamb(1981) proposes care managers to be therapists as well as brokers of services(Fisher, 1990,p.213). DeWeaver & Jonson (1983) look at the job descriptions of care managers in ten different settings and reveal certain stated values in common. Those which appear most frequently are the client's rights to the least restrictive environment, and advocacy on the client's behalf (Renshaw et al.1988,p.98). However, a number of authors are critical of aspects of the brokerage approach, arguing that brokerage functions are insufficient on their own to produce effective care management. Brokerage and coordination are not seen as mainstream tasks, rather the main focus is upon 'gap-filling' and upon liaison with other services(Askham & Thompson,1990; Challis,1994,p.97). Kanter (1987) also argues that 'care management is more than a brokerage response involving the exercise of judgement,

skill, counselling and other activities'(Challis,1994,p.102). Ballew & Mink (1986) suggest that the role of the care manager is seen as combining brokerage with interpersonal skills since it is focused both 'on the network of services needed by multi-problem clients and the interaction between members of the network'(Challis, 1994,p.93).

The brokerage care management model depends on community agencies to provide the services identified in the care plan. By serving as brokers, care managers have limited control over those agencies and their staff that see clients on a daily basis(Appleba & Christianson,1988;Torres,1988; Netting, 1992, p.162) . For those with a severe disability, brokerage may be less acceptable and less effective in enhancing quality of life(Huxley & Warner,1992,p.802).

Table 2-1: Models of Care management

| Model | Main Characteristics | Weaknesses | Strengths | Application To Korea |
|---|---|---|---|---|
| 1.Generalist | Taking all responsibility by one worker. Short-term task-centred work. | Dependency on single worker. Balance of duties. | Clear accountability. Speed of response. | Rural Urban |
| 2.Clinical | Assessment & reassessment is crucial. | High level of training and experience required. | Ideal in mental health setting. | Urban |
| 3.Administrative | Separating assessment from provision. | Danger of bureaucratisation. Possibly inappropriate provision. | Efficiency of coordination. Cost effective use of staff. | Urban |
| 4.Decentralised budget | Purchaser/provider split. Devolved budget. | Potential conflict of purchasing/advocacy function. | Wider choice. More responsive services. | |
| 5.Single agency | One agency in role. | Narrow definition of services. Risk of anachronistic services. | Easy to coordination. Clear accountability. | Rural |
| 6.Joint agency | Designated workers drawn from key Agencies | Inter-professional rivalries. Creating pooled resources. | Cost effective use of resources Creating multi-purpose workers | Urban Rural |
| 7.Rural | Coordinating informal services. Use of health care system. | Lack of available and accessable services. Constraints on delivery services | Use of informal services. Close relationship between users & workers | Rural |
| 8.Urban | Coordinating fomal services. Specialised care workers | High level of training required. | Flexibility of services. Wide range of resources. | Urban |
| 9.Brokerage /Advocacy | Just for brokerage & Advocacy | Limited control over agencies. | Close relation ship between users & worker | Rural Urban |
| 10.Social skill/Assertive outreach | Focus on strengths rather than pathology | Heavy emphasis on staff team work | Long-term care Rehabilitation work | Urban Rural |

## Implications of factors related to care management for community care for elderly people in Korea.

*Care management in Korea*

Care management has recently become one of the popular terms in academic society and in the social welfare practice sector in Korea. For example, since 1993 a range of research and books on care management have been, including MA dissertations(4), Ph-D theses (1), books(3), and articles(15). The concept of care(case) management was introduced by professor Kim,MD.(1993), who translated Moxley's book(1989), *The Practice of Case Management,* into a Korean version.

Some issues on community care for elderly people in Korea are similar to those in countries such as the UK and USA. A current major issue in community care in Korea is the uncoordinated services, divided into many delivery systems such as health and social care. Furthermore, there are insufficient social and health services for elderly people in community care, with many elderly clients not receiving appropriate services on time in Korea. The problems that elderly clients face in community care are not merely the complexity of services but also the absence of services(see chapters four and five). There are only a few voluntary and private services available in a mixed economy of care in rural areas. If care management is implemented in Korea, a care manager is likely to have a number of tasks - mainly a coordinator in an urban area, but a linkman and a service developer in rural areas. Therefore a provisional definition for care management for elderly people in Korea is proposed

as:

Care management is the mechanism to organise services needed by dependent elderly people and their carers, based on their preferences and needs based assessment under existing legislation. Care management is not only to coordinate the services and is link members of service networks of a mixed economy of care, but is also the development of appropriate services needed by elderly people in a community.

*Needs and community care for elderly people in Korea*

Lee, SY.(1997) argued in his Ph-D thesis that elderly people's basic needs such as clothing and food have now been largely satisfied. Therefore, a new social need for a better quality of life becomes a major social concern in Korea. Thanks to the improvement of social and economic conditions, the alienated elderly group hidden in the shadows of economic development have increased demands for their needs satisfaction as a social right(see chapters one & four). A recent elderly people's demonstration in Pagoda Park in Seoul is one example of the call for a new social policy direction for elderly people. The widespread perception of relative and social needs among elderly people today poses a formidable challenge to society for further development of social and health care in community care in Korea.

The state has a new duty to protect vulnerable elderly people who are childless or under the poverty line mandated in the form of community care, a duty mainly placed on national or local administrative health and social care offices. The state has tended to define needs in terms of categories of clients, such as the elderly clients group, rather than clients individual needs. Elderly people's needs are defined by a publication of the Ministry of Health and Welfare as:

'primary needs - physical, economic, socio-psychic, and housing needs'; and 'secondary needs - education, culture, recreation, and transport needs' (MHWRK, 1995; Lee,1996,p.15). Services are described as home help, transport, and day care centre(Lee,1996,p.15). As BASW(1977) argued, a danger of allocating services based upon client groups is a tendency to end up with lists of categories which do not take account of the full constellation of individuals' needs(p.32). Furthermore, as presented in the previous discussion on objectives and social needs, it means that elderly people's needs are defined by administrative officer/professionals rather than clients themselves. Social workers and nurses employed by local government usually play a key role in defining eligibility for a range of crucial elderly clients' needs in community care in Korea(see the section two in chapter five). Therefore, services in community care are not provided on a users-led approach in Korea.

*Feasibility of care management models in community care in Korea.*

Four categories of models implemented in western countries have been identified - organisational, inter-agency, locality, and primary contents models. The organisational models - clinical generalist, administrative, and decentralized budget control model - indicate that authorities and agencies have to decide whether separate staff should be identified with specific care management responsibilities or whether staff can undertake care management as part of a wider range of responsibilities. Inter-agency models, single and joint agency model, are

discussed on the basis of various combinations of agencies in different relationships with one another. Locality models raise the issue of how does care management in rural areas differs from that in urban areas. What are the strengths and problems of rural care management ? Some discussion of primary content models, social skills training/assertive outreach model and brokerage models are given(see models of care management).

Care management in Korea is likely to develop initially as a response to the problems relating to service fragmentation, poor/lack of resources, and the difficulty of interweaving statutory and informal care effectively(see chapter five). At this point it is difficult to say that any specific models of care management are feasible in community care in Korea, because care management models vary according to a number of criteria(see a previous discussion on care management models). Furthermore, it is not sure that some preconditions of operating a care management exist in Korean society(eg. purchasers & providers split). However, although the models may vary and whether the preconditions exist may be unclear, Korean evidence makes it clear that an effective delivery system is needed for the provision quality of cost-effective services. This is one of the urgent issues in community care in Korea. The establishment of the Health and Welfare Centres in 1995 for community care has provided a crucial opportunity to introduce and develop care management as a new addition or an alternative of the current nationwide service delivery system(see chapter four). The introduction of care management techniques to develop services and improve coordination through these centres would be an important project. The ten types of care management defined above could be feasible in

terms of service development and improving coordination. However, in the light of the initial survey of the Health and Welfare Centres, the government policy, and service resources available, it is identified that the two important outcomes are likely to influence on the development of care management. First, the Health and Welfare Center Project, one of community care policy, has been concerned with joint collaboration working between health and social care. Second, there are strong regional variations, especially between rural and urban areas, and imbalances in available services(see introduction and chapter four on models). Therefore, the most feasible models are likely to be a joint agency model and a rural and urban model.

## INTERNATIONAL STUDIES ON CARE MANAGEMENT

There are many reasons for exploring international perspectives on care management. International studies with different characteristics offer the opportunity to gain a deeper and broader understanding of care management issues than from a single country. To understand a particular aspect of welfare provision, such as care management, it is necessary to know 'how it fits into the wider social welfare systems and cultural expectations of the country concerned'(Tester, 1996,p.4). However, as Tester argues, there are many difficulties of conducting international studies such as methodological problems about what and how to compare and practical considerations concerning obtaining and reliability of data. Such difficulties are compounded by the researcher's lack of knowledge of countries and languages(p.4).

Three countries - USA which is a pioneer in care management, Japan which is most similar to Korean society, especillay the welfare system, and the Netherlands - are chosen for the study of the international literature on care management for elderly people. The practical reason why we choose these countries is data/literature and availability in English. The UK literature is considered separately in chapter three.

### The USA

American case management, as mentioned earlier, has developed in welfare service contexts(see origin of care management in chapter two). Various definitions of case management have appeared in American literature. Their common theme suggests

that 'case management is a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner' (Intagliata,1992,p.28). A variety of objectives of case management have also been stated within the projects. Perhaps the most fundamental of these is to enhance the continuity of care provided to clients, to improve accessibility and accountability within the service system, and to enhance the efficiency of service delivery within the system in the USA(Intagliata,1992,pp.28-29).

*History and policy*: Rothman argues(1991) that 'the emergence of case management as a distinct concept was linked to the rapid expansion of categorical arrangements in welfare services during the 1960s in the USA'(p.520). During the early 1970s, the Department of Health, Education and Welfare funded a series of demonstration projects to test various approaches to improving the coordination of federal service programs at the state and local level(Mittenthal,1976; Morrill, 1976;Rubin, 1992 ,p.6). Congress in the Developmentally Disabled Assistance and Bill of Rights Acts (1975) mandated that each client should be assigned a 'program coordinator' responsible for implementing the person's individual habilitation plan and attending to the total spectrum of the person's needs. The 1978 version of the Acts specially mandated that coordination should be achieved by the delivery of case management services to all eligible persons(Intagliata, 1982,p.657). During the late 1970s, the National Institute of Mental Health funded demonstration projects in 19 states to implement and test its services integration concept, which was termed the 'community support

system' (Turner,1977;Turner & Shiffren,1979;Rubin,1992, p.7). The need for case management constitutes an indictment of existing organisational and interorganizational patterns of service design and delivery(Rose,1992,p.vii), because the human services in the USA have traditionally resembled the mixed economy of care which conservative governments have been keen to develop(Sturges ,1996,p.36). It means that delivery systems become more complex, with a fragmented array of separate programs(Rothman,1992,p.93). Given a high level of fragmentation, it has been necessary for service users to use advocacy in order to insure that services were received by clients(Applebaum & Austin,1990;Sturges, 1996,p.36). Sturges (1996) analysed the reasons for the development of case management in the USA: in order better to co-ordinate community based services; to deter premature institutionalisation/unnecessary hospitalisation; to improve the quality of people's lives(p.35). However, Rothman(1992) argued that the introduction of case management with long-term care in the 1970s deflected concerns of insufficient resources available(p.93), 'with an undue preoccupation with accountability and cost-effectiveness in service delivery' (Weil,1985;Rothman,1992,p.93). Intagliata(1992) summarized well that the rapid expansion of human service programs created a sprawling, fragmented network of services. The subsequent attention given to the difficulties experienced by consumers in general, and to deinstitutionalisation, has led to the current widespread interest in service integration techniques, especially case management(p.28).

*Characteristics of practice:* Case management is frequently presented as a process comprised of multiple functions

without specifying the persons or structures responsible for carrying them out(Intagliata,1992,p.30). Among the many possible structure elements that could be developed to implement case management, two have been specified as essential. The first is the case manager who provides coordination and integration of services at the clients' level. The second is the core agency which is responsible for coordination and linkage of program at the local system level(Rothman,1991,p.520).

There is a group of generic core tasks which case managers perform in the USA. Five typical case management functions regularly appear: needs assessment, care planning, linking or referring, monitoring, and advocacy(Rose,1992,p.vi). Evaluation is sometimes included as a core task for care managers and monitoring is viewed as crucial because it is essential to continuity of care and to prevention, as major goals in long-term work with vulnerable people(Sturges, 1996,p.37). Less developed have been the community practice skills required to develop needed resources proactively in local communities. There has been resistance to letting case managers provide counselling in long-term care and this has been one weakness of practice there. Case management is used in a wide range of settings and with many client groups. It can be found in community based programs where most of the work is done in people's homes, day care centres, and in hospital and nursing homes. More recently, according to Sturges(1996), it has been performed as a type of private practice, predominantly by social workers and nurses with elderly people(p.40).

It is generally agreed now in the USA that there is no one profession that is most able to undertake case management.

There is on-going debate about the level of education required and whether this is a method of practice which requires a high skill level. It ranges from a high school diploma to a doctoral degree and may depend on what a given program expects the case manager to do(Intagliata, 1992,p.41). Paraprofessionals are sometimes used as case managers in the USA in order to reduce costs. However, according to Rubin(1992,p.13), Lamb (1990) and Kanter(1985) argue that a case manager without graduate training has difficulty working effectively with elderly people who have mental health and substance abuse problems. Especially where care management can grasp political and economic priorities and their interaction, it will enhance its leadership potential. There is a good reason to believe that workers with master degrees, or possibly with BA degrees will be required.

National Association of Social Work(NASW) strongly urges the use of professional social workers in all aspects of case management services delivery. The use of qualified social work professionals in case management is seen as the primary means of assuring the quality and comprehensiveness of client services. NASW strongly argues for schools of social work at the BA and MSW level to include in their curriculum the specific knowledge, methods and techniques of the case management models(NASW,1992,p.24). Social workers and, increasingly, nurses are most likely to be case managers in long-term care. The development of a case manager training program is regarded as an essential component in the building of any effective case management system. Intagliata(1982) suggested that the statewide training package for all trainees should focus on the basic aspects

of the case manager role. This includes the rationale for the case management process and the values that are intended to guide the activities of case managers(p.666). Additional modules depend on different population groups of clients. Caseload size is still an important practice issue, depending on the type of client, and the complexity. The number of clients that a case manager can serve effectively will be dependent on the mix of clients' levels of functioning, the degree to which clients live close together or in scattered locations, and the competencies of individual case managers(Intagliata,1992,p.47). But research in the USA suggests that a caseload in elderly mental health that exceeds forty is often associated with reactive rather than proactive work and with burnout(Rose,1992,p.ix). Estimates of the ideal caseload size vary, depending on client attributes, their geographic proximity to one another, and the case manager's competencies (Rubin,1992,p.15).

*Models of practice:* There have been so many kinds of case management models in the USA that 'some have asked whether it is a distinct model of practice after all'(Rothman, 1992,p.3). Case management models vary according to a number of criteria. These include the client group with which case managers are dealing, their position and level within the service system, whether or not they have authority to co-ordinate resources across agencies, definition of their role, etc.(Beardshaw & Towell, 1990,p.17). However, most models of case management agree that the roles of case managers are diversified, tasks are multiple, and responsibilities range from the personally involved broker of services through advocate to primary therapist (Lam,1980; Harris & Bergment, 1987; Rose,1992, p.vi). It means that each model must

confront the dual responsibilities of providing direct services to clients and system intervention (Rose,1992,p.viii). It would be impossible to describe the whole range of models that have been used in the USA. What follows is one case study, which describes one of the interesting types.

Case I: Family members as case managers

One of most interesting case management experiments in the USA was an effort in Boston to train families to do case management with their frail elderly relatives. Elderly persons(mean age=83) were randomly assigned to either an experimental group in which family members participated in a case management training program, or to a control group. Following training, family members in the experimental group performed a significantly greater number of case management tasks on behalf of their elderly relatives than family members in the control groups. The duration of service was significantly shorter for elderly people in the experimental group(Seltzer, Ivry, & Litchfield,1992 pp.229-237). However, there were some questions posed by the researchers. First, are the effects of the family centred training durable ? Secondly, how generalizable are the findings of this study to the general population of elderly and their family members ? Thirdly, can the case management training be delivered in formats other than individual case-by-case training conducted by social workers ? Finally, can the elderly person be trained to serve as a member of the case management team along with the family member ?(Seltzer, Ivry, & Litchfield, 1992, pp.240-1).

*Outcomes of case management:* Evaluation of the effectiveness of case management is obscured by the limited amount of research available in this somewhat recent field (Baker, Intaglitate & Kirshstein,1980; Caragonne,1981 ; Franklin et al,987;Rothman,1992,p.63). Case management programs, according to Rothman(1992,pp.64-65), have been found to positively affect client adjustment to life in the community and reduce the occurrence of reinstitutionalization (by Bruce & Buehler, 1973;Smith & Smith,1979;Bigelow & Young, 1983; Modricin,Rapp & Chamberlain, 1985;Rapp & Wintersteen, 1989).

Provision of case management services has frequently been associated with improvements by clients on quality of life indices (by Caragonne,1980;Field & Yegge,1982; Goering, Wasylenki, et al.,1988). However, a number of studies have cast doubt on the effectiveness of case management (by Byers, Cohen & Harshberger, 1978; Callahan,1989; Coulton & Frost,1982 ; Franklin et al.,1987; Wasylenki,1985)(Rothman, 1992,pp,p.69). It means case management holds great promise but we need more stringent empirical research before any meaningful generalization can take place.

## The Netherlands

According to Davies(1992), the first care management project in the Netherlands was based on the first British experiment, the Kent Community Care Scheme(p.31). Care management is defined in many ways in the Netherlands. Koedoot, Hommel, & Knipscheer (1994) stated as a general definition:

'care management is a specific kind of care coordination on an individual(micro) level, tailored to people with complex care needs who are dependent on more than one care provider'(p.160).

From a number of projects, Coolen(1993) summarized the objectives of care management in the Netherlands:'to increase coordination and integration between care providers'; 'to reduce the use of institutional care'; 'to reduce the cost of the elderly care'; and 'to increase matching of formal services and the (potential) activities of informal support networks'(p.2).

*History and policy*: In the Netherlands, social services have been controlled and managed by a different set of government

departments, local authorities, and agencies(Illsley & Jamieson,1990,p.86). Therefore, increasing care expenditure, a fragmented care system, and individualisation have all been put forward as arguments in favour of care management(Keodoot & Hommel, 1993,p.160). Since the beginning of the 1980s, much attention has been given to 'containing cost increase and improving efficiency' in social services(Coolen, 1995,p.126). At the end of 1986 a new official memorandum, the 'Nota 2000', was issued by the Ministry of Welfare, Health and Culture Affairs. The Nota 2000 advocated placing facilities in a less central position and more emphasis on individual circumstances and the need for care. In 1990 a policy document(Werken aan zorgvernieuwing) was presented by State Secretary Simons as a programme of action. It is recognised that a central place must be allocated to quality maintenance and monitoring in care. Proposed measures include strengthening the functional link between different types of provisions, preparing the complete integration of professional help with home care(Tunissen & Knapen, 1991a,pp.20-21). It thus becomes easier to obtain a care package tailored to individual needs.

*Characteristics of practice:* Family doctors and district nurses act usually as care managers, called care mediators (Rotterdam). The nurses(first level) usually hold a BA degree. The district nurse as a care manager is responsible for all stages of the caring process, as well as the continuity and co-ordination of care (Jansen et al.,1997, p.222). Care management is intended to facilitate a shift from extramural to intramural care in accordance with the government objective in care for elderly people(Koedoot &

Hommel,1993,p.75). A general process of care management is defined by Koedoot & Hommel(1993) in six steps: assessment; planning; linking; monitoring; evaluation; and advocacy. Case managers use a formal and standardized intake system for clients, called 'Landelijk Indicatie en Registratiesysteem' (National intake and documentary system) in order to assess and allocate the quality and quantity of care(Heuvel,W. & Gerritsen, H.,1991,p.220). A rather unique measure is the introduction of a personal budget that can be allocated to elderly persons who are eligible for long-term institutional care. By means of such a budget, a home care package can be organised with expenditures being at most two-thirds of the costs of residing in an institution (Coolen,1994,p.75). However, care managers are confronted with a number of problems in the performance of tasks and duties. They lack the authority to organize activities in the field of formal care and are dependent on the goodwill of service organisations(Cooln, 1993,p.86)

*Model of practice:* During the period of 1988-1991 on both local and regional scales, several kinds of care management were implemented in home-based care. First was the project for co-operation between professionals and organisations. The main idea was to create a focal point for different types of primary health care staff in order to provide care geared to individual needs, discuss problems, and exchange information on a regular basis. The integration project in Venlo and St. Philipsland were top-down attempts to improve co-operation between different services at municipal level(Tunissen & Knapen,1991b,p.100). Second was the co-ordination at the local level. New policy experiments were designed at the local level, which entailed a combination of supply-side and

organisational interventions. For instance, in the province of Groningen, organisational interventions were: building district teams of home helpers and home nurses, in order to perform the relevant collaboration; developing a common method of need assessment, in order to facilitate an efficient allocation of home care; developing an integrated registration system, in order to sustain professions in an ongoing monitoring of clients with complex problems. Supply-side interventions involved extending the service capacity of community care(Coolen ,1995,p136).

Third was the organisational and financial integration of provisions. Many co-ordination projects were carried out within the framework of a rather fragmented planning and financing of long-term care, which imposed limits on flexibility in dealing with the health problems of clients. The organisational and financial integration of provisions generated more flexible and efficient long-term care for vulnerable clients. The successfully implemented interventions which generated the organisational and financial integration project in Nieuwegein showed relatively high levels of co-ordination and flexibility(Coolen ,1995, p.137).

Case study I: Hospital-at-home scheme in Rotterdam

Private funds and subsidies from the municipality of Rotterdam and the Ministry of Welfare, Health and Culture cover additional costs. Home help agencies and health care centres used their own budgets for staff and extra facilities(Tunissen & Knapen, 1991b,p.117). During the last four months of 1987, the project set up home teams for 27 patients in the terminal stages of cancer to improve co-ordination between the organisations involved (Tunissen & Knapen, 1991b,p.115). In all, a total of 611 days of care was provided by the home teams(average 43.5 days per patient), varying from less than one week to 160 days per patient. Most patients were over 60 years old. Twelve patient lived alone, 14 lived with their partner; some had children

(Tunissen & Knapen, 1991b,p.117). A home team consisted of all necessary care providers, including relatives and volunteers. One of them, usually the family doctor or the district nurse, acted as the home team co-ordinator(care manager). The home team met regularly to discuss the situation, assess the amount and quality of care needed, and set up schedules. There was a logbook for each patient in which all relevant data were recorded(Tunissen & Knapen, 1991b,p.117). The availability of home team care was flexible and partly depended on what relatives or other volunteers were able to provide. The project co-ordinator was responsible for communication between the task force members, and for development work within the project. If necessary, the project co-ordinator requested further information, set up meetings, and solved problems together with the task force. After a patient dies, an evaluation is essential. The members of the home team meet to discuss the care process and mutual co-operation. If necessary, follow-up support of the patient's partner and members of the family was provided(Tunissen & Knapen,1991b, p.116). In the project, there were some problems. In some cases the interests of relatives and professional care providers clashed. The services allocation often asked caused friction. The request to set up a home team was often left until the patients's condition was critical(Tunissen & Knapen, 1991,p.117).

*Outcomes of care management:* Most studies reported some reduction in the use of institutional care. But, although some projects demonstrated considerable lower costs than normal services for elderly people(Koedoot & Hommel,1993, p.86), most studies in innovative programmes did not report cost saving(Coolen, 1995, p.125). According to Cooln(1993,p. 193), Wessert et al.(1989) presented an extensive survey of empirical studies, intending to draw overall conclusions on the effects of care management in community care. Their findings were briefly summarised as follows:

"Most studies noted a reduction in the use of nursing homes, but this reduction was small; most studies did not report savings; there is no clear evidence of positive effects on the health status involved in care management service; and beneficial effects were, however, evident with respect to the well-being of client and their carers"(Coolen,1993,p.193).

## Japan

Care management is a relatively new brand of service delivery mechanism for elderly people in Japan. Although American case management was introduced in a book or a journal in Japan earlier, it was not until 1989 that a first care management project was launched in Sapor(Maeda et al.,1994,pp.2-3). A care management definition given by Maeda & Takahashi (1992), who were involved in a care management project in Sapporo in Japan is:

"a new approach toward comprehensive health and social services for clients and for their care givers, reducing the heavy burden of care by family members and preventing unnecessary hospitalisation" (p.5).

Comprehensive delivery of care based upon a planning process was emphasized through care conferences(care management), which might count around 80 programs in Japan if every program from public and private services applicable to at least one individual in the community was chosen(Maeda et al., 1994,p.4).

*History and policy:* During the 1980s, the major area of reform in the welfare sector concerned the perceived overuse of medical and hospital services by the frail elderly(Usui & Palley,1997, p.370). The government set up the 'Gold Plan' of 1989, which encouraged the deinstitutionalisation of frail elderly people by supplying increased levels of community care. It stressed the need for a community care delivery mechanism to cope with fragmented health and social care services and to keep the elderly people in the community rather than institutions (Usui & Palley,1997,p.372). The Japanese Ministry of Health and Welfare of the central

government has provided a grant for the special program for service coordination in the care of frail elderly people in the community at the municipal office level since 1989(Maeda & Takahashi,1993, p.445). The main focus of this program has been the regular care conferences between different offices and staffs(Maeda & Takahashi,1992,p.5). The Gold Plan of 1994 reflected active designs by the national government to rationalise response to the rapidly changing needs of elderly people and their families (Usui & Palley, 1997,p.376). On the basis of the 'Keigo(care) Insurance Act' passed in 1997, as of 1998 responsibilities for service delivery including assessment has been transferred into local authorities and 500 workers as potential care managers have been employed by the government(Kim,1998, phone interview).

*Characteristics and model of practice:* One of the projects was in Takasu for the purpose of informing clients of the care and services which were available, helping family members to be caregivers, and economic and social evaluation of care management in the long run.

Case study I: Takahasu project(Sapporo)

Care conferences were held twice a month with the aim of discussing two to four clients each time in order to assess the care needs of frail elderly people. The conference included every key health care and social service provider in the town(the physician, public health nurses, social workers, home helpers and the administrative staffs of the municipality(Maeda & Takahashi, 1992,p.6)). An economist (Ph-D candidate) was nominated as a care manager(p.7) and later a doctoral degree holder took over the tasks of a care manager(Maeda et al.,1994,p.13). Care planning, implementation and the reassessment of care had been achieved through two-hour care conferences. Between Oct.,30,1989 and Jan.,24,1992, they held 38 conferences for 38 elderly clients. However, they never had any definite criteria for the clients' selection. Rather, the members of care management groups tended to select clients who needed services from a mixed economy of care(Maeda et al.,1994,p.7). They presented three examples of

individuals whose care was organized by the care management approach. The impact of the type of care they received on the costs of care was given particular attention. These cases were to illustrate lowest, average, and highest costs of care among the clients receiving care management(Maeda & Takahashi, 1993,p.443).
Maeda et al.(1994) evaluated how the project developed a comprehensive and systematic approach to the needs of long-term care in the community, especially, its needs oriented approach through care planning by a team(p.16). Furthermore, the most outstanding result of the implementation of care management was the dialogue created between different experts in health and welfare services (Maeda & Takahashi,1992,p.9). However, care management in Japan raised the issue, who would be the care manager concerned with authority between clients and the service organisation ?

*Outcomes of care management:* care management is being implemented in several municipalities in Japan under the auspices of a plan titled 'coordination project for elderly people'. Several projects have already reported success. However, the number of cases in the study was not sufficient to clarify the effectiveness of care management (Maeda et al., 1994,p.17).

## Conclusion: Lessons from international studies

Internationally there is great variation in national policies and the ability and willingness to develop care management (see the previous subsection). We can not transpose any specified approach from these examples for the development of care management in community care in Korea(see significance in introduction). However, we can learn from their experience and suggest frameworks for approaching issues on care management from selected international contexts.
In those three countries, there was no government mandate nor guidance like the White Paper or Community Care Act in the

UK as statements of national policy from which systems could be developed for a whole range of clients, even though the Keigo Insurance Act was recently passed in Japan. Therefore, care management has been ill defined and sporadically implemented in those countries. Pilot projects began in the USA in 1970s, the Netherlands and Japan in the late 1980s, and care management is being widely recognised across a range of population(Sturges, 1996, p.33).

Care management becomes a service strategy to achieve the goals contoured by deinstitutionalisation, cost containment, coordinating services, and enhancing need satisfaction through the development of a mixed economy of care and purchasers/providers split in community care in those three countries. Especially, care management has been an attempt to solve the administrative chaos of privately funded health and social service sectors in Japan. In the Netherlands, care management has been for a coordinated funding system; different service providers had to be paid independently and funding came from a number of different sources(insurance, private payments). On the other hand, the USA has been not simply concerned with coordinating appropriate services for individual clients but has also been concerned with controlling the number and type of cases and managing overall state expenditure in the projects. These considerations made care management a necessity for setting up packages of care in those countries.

From the international experience, the first obvious corollary is to ask which profession emerged as the most appropriate in care management. Many projects employ social workers as care managers in the USA, although community nursing is also commonly encountered. However, in the

Netherlands, community nurses mainly take the role of care managers. It may be most appropriate to employ nurses in case where there are medical problems, or liaison with health services agencies is particularly important. Social workers may be most useful where social care is heavily involved in community care.

Secondly, Research, as Intagliata(1982) argued, suggests that a large increase in caseload size may impair the quality and effectiveness of care management by reducing the care managers' contact with clients, and predisposing them to respond to crises rather than anticipate problems and help clients plan ahead.

Thirdly, the development of a care management model attempt to enhance the clients' needs satisfaction by best use of the available resources within the existing system. The model varies with the context within which it operates: a complex system is likely to require a more complex model. In settings where resources are scarce, care managers may make use of their own time more as a service (Renshaw et al, 1988,p.111). It is important that in any discussion of care management developed by a particular country, both functions and dimensions of care management are specified in detail according to that country's conditions. For example, In the USA, the problem that elderly people faced was not merely the complexity of services but also their absence and difficulties in financing their use. Therefore, American case management makes more of the brokerage and advocacy roles open to the case manager.

In terms of outcomes, identical innovations can produce different results in different countries, depending on the structure of health and social services in a particular

society, for example its supply of provisions and financing. What emerges from the international experiences is that care management is only effective under certain limited conditions. Considering this issue, Japanese system is the most similar to Korea, especially underdeveloped voluntary sector, family-based care for elderly people.

To sum up, although there is internationally a growing literature to try and explain the various models and organizational arrangements designed for their implementation, as Fisher(1991) argued, 'evidence of confusion about precisely how they can be best operated in practice in Korea has also emerged locally'(Hughes, 1995,p.93). Furthermore, its implementation has been used as a vehicles for inserting market principles and structures into the organisation and delivery of welfare. Thus, care management has been linked inextricably to the so-called 'mixed economy of care' and 'the purchaser/ provider split' which are regarded as crucial preconditions for the potential application and development of care management in community care(see conclusion in chapter three), despite the fact that such a link is nether essential nor desirable(Cambridge,1992; Hughes, 1995,p.94). Another important precondition for operating care management is the systemic factor. It creates a focus for the care management activity which brings with it inevitable questions about the development of staff as care managers(eg. social workers, nurses) and staff training covering care management(eg. training for senior managers, volume training for community care, management development training for front lines supervisors and managers).

From these, some lessons for Korea from international studies appear to be: (1) Care management cannot itself produce co-

ordinated care; a necessary pre-requisite is the integration of services through a mixed economy of care, which is essential to enable care managers to address various levels of need with appropriate provision of services;

(2) Care management, as Dant & Gearing argued(1990), will only work if the care manager has control over the supply or availability of services and other resources through the purchasers/providers split(p.344). We have not to forget Rose(1992)'s argument: 'as a consequence of the absence of the prerequisites, care management must become a system reform strategy with responsibility for direct practice with individuals'(p.viii).

There may be no possibility of developing care management in community care for elderly people in Korea if necessary preconditions are not met for its development.

International studies of care management raise the question of whether those three countries' experiences, especially the USA, are more relevant to Korea than is on that of the UK. It is too early to reach a conclusion on this point. But, it is expected that the UK experience offers more lessons for Korea than any other country, for following reasons:

(i) Unlike other countries mentioned above the UK has statements of national policy, a White Paper/Community Care Act, from which systems can be developed for a whole range of vulnerable people by a systemic approach.

(ii) Those three countries' care management has the integration of diffuse and fragmented service systems as its primary focus. On the other hand, the UK care management has additionally emphasised the function of service development. Further discussion about this issue is found in the final section of the next chapter.

# CHAPTER III

# COMMUNITY CARE AND CARE MANAGEMENT IN THE UK

Looking at policy statements such as the over three decades from individual countries as well as international organisations, OECD, they all point to the importance of community care for elderly people. As Jamieson(1989) argue, community care is no longer a new concept(p.446). The UK is one of many countries with a policy of community care for elderly people with determined efforts to link theory to community care practice(Jones,1989,p.103). The UK has obviously gone ahead of Korea with community care for elderly people. It has already faced many the issues and devised solutions to problems waiting for Korea in the near future in community care.

This chapter reviews community care for elderly people with lessons from successes as well as from failures in the UK. The first section focuses on policy changes in community care since 1950s, seen in a series of reports which progressively refined and defined problems and solutions over four decades. The second section presents the main factors affecting the development of community care for elderly people, such as socio-demographic, political/ economic factors, the preference of elderly people, and grass roots pressures. Section three discusses an effective approach to community care for elderly people, namely care managers and care management. In conclusion, some implications of community care and care management in the UK are explored for Korean society.

## POLICY DEVELOPMENT OF COMMUNITY CARE FOR ELDERLY PEOPLE

The origin of 'community care' is not clear. According to Finch(1990), some of the ideas which it incorporates can be traced at least to the early part of this century(p.35). However, the 1950s are chosen as a starting-point for a discussion of the social policy aspects of community care, because the first official appearance of the term community care was in *the Law Relating to Mental Illness and Mental Deficiency* (Cmnd.169) published by the Royal Commission in 1957 and followed the first legislative steps towards community care(Tinker et al., 1994,p.97).

This section reviews the policy development of community care for elderly people as seen in policy documents from the 1950s to early 1990s. They have a number of different and common features which have mainly focused on demographic & economic issues(eg.*The Phillips Commission Report,*1954) in the 1950s, the economic and service delivery issues(eg.*A Happier Old Age,*DHSS,1978) in the 1960s/1970s, and cost-effective and service management issues(eg.*Griffith report,*1988) in the 1980s/1990s.

### The 1950s: The origins and development

The rising elderly population, particularly very elderly people, financial constraints, the reaction gainst large, old fashioned hospitals(Tinker et al., 1994, p.97), and the development of medical treatment (Goodwin, 1989,p.28) had mainly created the climate for community care in the 1950s.

Table 3-1: Elderly population in the UK(1901-1959)

Thousands

| Age\year | 1901 | 1931 | 1951 | 1955 | 1959 |
|---|---|---|---|---|---|
| 65-74 | 1277 | 2460 | 3690 | 3772 | 3991 |
| 75+ | 537 | 957 | 1779 | 1993 | 2153 |

Source:CSO(1961), Annual Abstract of Statistics, HMSO

The Phillips Committee's report(1954), *The Economic and Financial Problems of the Provision for Old Age*(Cmd.9333), reviewed the economic and financial problems involved in providing for old age, having regard to the prospective increase in the numbers of elderly people(see table 3-1). This report emphasised the need for the development of home care and the importance of people in institutional care retaining a community orientation in order to reduce financial pressure on the State as well as to satisfy elderly people's preference. In the recommendation of the report:

"to enable old people to live in their own homes where they can continue to be happy and useful members of the community, in touch with their relatives and neighbours. Special housing of various types suitable for the old, but not isolated from the rest of the community, will therefore be needed"(p.83).

Another climate for community care was the reaction against large, old-fashioned, outmoded and isolated Victorian hospitals(Tinker et al.,1994,p.9) and development of medical treatment(Goodwin,1989,p.28).

*The Law Relating to Mental Illness and Mental Deficiency* (Cmnd.169) published by the Royal Commission(1957) officially emphasised the shift from hospital care to community care which covers all types of care in the community:

"generally considered in the best interests of patients who are fit to live in the general community...For those who cannot live with their own relatives it is considered more appropriate to provide residential homes in towns and villages ...many of the patients now in hospital should be immediately acceptable as members of the general community, where they would already be if they had families or friends with whom to live" (p.207).

In respect of the development of medical treatment, the development of community care was encouraged by the Ministry of Health(1958,Cmnd.806):

"It was only comparatively recently that powerful therapeutic weapons had been put in the hands of the medical staff, who for many years had very limited prospects of curative work(p.22)...prolonged periods in hospital have become less necessary...One of the most important has been the development of improved methods of treatment"(p.23).

Equally, the Ministry of Health(1959,Cmnd.1086) maintains that: 'the shift in emphasis to community care recommended by the Royal Commission is based on developments in medical treatment in recent years'(p.7).

Throughout the 1950s the government report made frequent reference to the need to develop community care as a means of enabling elderly people to remain in their own homes. However, as Goodwin(1989) comments, the introduction of community care by Ministry of Health in the 1950s' was not so much generating a new and progressive policy as responding to changing circumstance(p.45).

## The 1960s/70s: The move to action

There were a series of policy initiatives which have promoted community care rather than residential care for a range of disabled, infirm and elderly people in the 1960s, which were partly due to the political acknowledgement of community care

for elderly people and an increased anti-institutionalization. The focus on 'deinstitutionalisation as a once and for all solution to the problem was particularly attractive to politicians'(Ramon,1991,p.x). The key concept behind this move was 'normalisation' (Jones, 1989,p.110). Scull argued that 'they could easily identify with this simple humanistic message, made doubly attractive by the possibility of reducing public expenditure through care in the community'(Scull,1977;Ramon,1991,p.x).

In respect of anti-institutionalisation, Peter Townsend (1964) reported in *the Last Refuge* that conditions in homes reduced the autonomy of the residents and isolated them. He concluded that 'the long-stay institutions failed to give residents' the advantages of living in a normal community and should be abandoned as an instrument of social policy. One of the alternatives was to develop domiciliary services'(p.190). A succession of research studies has demonstrated that institutional care for elderly people has involved a loss of liberty and independence, and moreover that a substantial minority of residents would be able to care for themselves in the community with minimum support (Walker, 1982,p.8).

The White Paper(DoH,1963) on *Health and Welfare, the development of community care*(Cmnd.1973) emphasised different aspects of care in the community:

"In the past the emphasis was on the provision of a range of services; now it is on ascertaining and meeting particular needs. In the future the services will be increasingly sensitive to the specific needs and individual characteristics of the people they are designed to serve"(p.3).

It is argued that the switch from institutional care to care in the community of elderly people meant that local

authorities had to think seriously about the quality and type of care that was appropriate to clients. Titmuss(1968) commented on community care policy in *Commitment to Welfare* with regard to community care, which may readily be applied to the phrase 'a caring society' today:

"It has been one of the more interesting characteristics of the English in recent year to employ idealistic terms to describe certain branches of public policy. The motives are no doubt well-intentioned; the terms so used express, in civilised phrases, the collective aspirations of those who aim to better the human condition"(p.13).

Although it is not easy to disentangle which factor had the greatest influence on the development of community care for elderly people in the 1960s, it can be said that the development of community care for elderly people in this periods resulted from a combination of government policy, anti-institutional care, and already established trends throughout the 1950s. By the early 1970s, as Finch(1990,p.36) argued, the ideology of community in general and community care in particular was well established across a wide range of services. However, policies to implement it were still in a relatively early stage. At this time, the emphasis tended to be rather more on care in the community than care by the community. Policy development of community care has tended towards assisting people to remain in the community rather than be taken to hospitals in order to reduce financial pressure through an extension of family and community support. The White Paper(DHSS,1971), *Better Services for the Mentally Handicapped*, proposed that:

"In future hospitals would be used for active treatment programmes, not residential care...Local authorities would provide residential accommodation in homes, not hostels, and other means of care such foster care, group homes and flats would be developed with social work support"(Jones,1989,p.109 ).

A shift in community care policy has taken place since the combination of the fiscal crisis of the mid-1970s. Attempts have been made to develop joint planning machinery to improve effectiveness and to define community care in the broadest possible terms to emphasise care by the community. In 1976 a Consultative Document, *Priorities for Health and Personal Social Services in England,* emphasised joint planning:

"When resources are limited it is clear that growth in any particular service can only be afforded if counterbalancing economics are made elsewhere...the encouragement of joint planning between health authorities and local authorities through the provision of special finance(p.2)... for the elderly co-ordinated planning is required across administrative boundaries" (DHSS,1976,p.41).

On the other hand, *Priorities in the Health and Social Services: The Way Forward*(DHSS,1977,p.9), described community care in the broadest terms:

"The term 'community' covers a whole range of provision, including hospitals, day hospitals, residential homes, day centres, and domiciliary support. The term 'community care' embraces primary health care and all the above services, whether provided by health authorities, local authorities, independent contractors, voluntary bodies, community self-help or family and friends"

In 1978 the Department of Health & Social Security Welsh Office issued their discussion document, *A happier Old Age* which looked both at the respective roles and services of the State and the family and neighbour in caring for elderly people(DHSS,p.13) and emphasised the importance of adjusting the balance of care to provide support by the community:

"The promotion of a satisfactory quality of life for elderly people and adequate provision for their care involve many different organisations and individuals. But the effectiveness of all the various efforts depends a great deal on the extent to which people work together...It is also important that we get the right balance between various forms of provision"(p.40).

In the 1970s community care was encouraged as 'a good thing' but not supported by financial incentives until the arrival of joint finance(Knapp et al.,1992,p.17) which provided for sums of money to be transferred from the NHS budget to the local services budget to finance projects. It was associated with joint care planning which required a system of co-operation on the planning of each development to be set up in each area(Wistow,1982;Payne,1995,p.38). However, the potential of joint finance was not realised due to a variety of legal, administrative and financial obstacles, particularly the long-term revenue consequences for social services(Challis et al.,1995,p.10).

## The 1980s/90s: The growth of public concern

The new Conservatives at the beginning of the 1980s emphasised the moral principles of individual freedom and individual responsibility based on a sense of personal responsibility, a concept of community self-help and a concept of individual rather than collective justice at the level of the clients in community care(Griffiths, 1983; Sullivan,1994,p.24). Otherwise, community care at the system level was mainly focused upon influencing the degree of co-ordination between health and social care through planning processes, financial transfers and financial incentives(Webb & Wistow,1986;Challis et al,1995,p.3).

The general aim of community care policies in the 1980s was to maintain an individual's link with informal networks for normal life, and to offer the support that meets his/her particular needs(DHSS,1981a, *Care in Action*: p.21). At the same year the consultative document, *Care in the Community*

(DHSS,1981b), suggested that:

"Most people who need long-term care can and should be looked after in the community. This is what most of them want for themselves and what those responsible for their care believe to be best"(p.1).

These reports emphasised the importance of care in the community in respect of patients'individual needs in order to promote better care and distribute the burden of caring for the disadvantaged more fairly. This represented a policy shift to greater attention to the needs of clients. Otherwise, the White Paper, *Growing Older*,(DHSS,1981c) argued the importance of statutory support for groups and individuals who provide direct support to elderly people: 'It is the duty of local authorities to sustain and develop informal care as care in the community which must increasingly mean care by the community'(p.3).
From 1980 to 1981 the DHSS undertook a series of studies of national policies relating to NHS and personal social services provision, covering the acute sector, the care of elderly hospital patients and community care. It emphasised collaboration in system levels:

"package of services rather than single service would have to be created for each individual to enable them to be cared for by community care...a package of services was seen to depend upon collaboration between health authorities and social services departments, both planning services and in their provision to individual clients"(Challis et al.,1995,p.3).

Since the mid-1980s, the main themes of community care policy through the reports have been the necessity of providing efficient and cost-effective management of community care, the inefficient and ineffective use of community resources, a lack of co-ordination and liaison between departments, and an adherence to the rights of clients and informal carers.

The Audit Commission's Report(1985), *Managing Social Services for the Elderly more Effectively*, set out to offer an approach for more effective management of local authority provision and expenditure for the elderly. The Report illustrates the inadequate management of community services and suggests:

"The overall objectives of providing individual services are often unclear; management's policies and guidelines... procedures and systems for controlling their use are largely absent. These weaknesses were especially apparent within the management of the largest community services, the home help service"(p.2)..."a more systemic approach towards managing services for the elderly will result both in more appropriate care for individual clients and also in better value for money"(p.10)

Since the late 1980s, community care policy has tended to ensure a more effective use of resources through packages of care and emphasised private and client-centred services. The Wagner Committee(1988), *Residential care*, recommended a reasonable package of services, enabling a person to remain in their own home if that is their choice and it is reasonable for them to do so. The Committee proposed that packages of care should be devised by a 'nominated social worker' who would be specially trained for direct control over financial resources(p.115). Shortly after the Wagner Report, care management(see chapter two) was proposed by the Griffiths Report(DoH,1988,p.vii), *Community care: Agenda for Action*, to create packages of care:

"The needs of individuals within the specified groups are identified, packages of care are devised and services co-ordinated; and where appropriate a specific care manager is assigned. The type of services to be provided would be derived from analysis of the individual care needs....these services are provided within the appropriate budget by the public or private sector according to where they can be provided most economically and efficiently".

A year later, a White Paper(DoH,1989), *Caring for People: Community care in the next decade nd beyond(Cm.849)*, defined four key components of community care which together reflected the emphasis on promoting choice as well as being cast in the language of consumerism.They are:

"Services that respond flexibly and sensitively to the needs of individuals and their carers, that allow a range of options for consumers, that intervene no more than is necessary to foster independence; and services that concentrate on those with the greatest needs"(DoH,p.5).

It is the main point of the White Paper(1989, Cm.849) that people who need it can find good quality care which suits their wishes and needs. Two main ways to achieve this were suggested by the White Paper:

"a comprehensive process of assessment and care management, which 'where possible should induce active participation of the individual and his/her carer', and a more diverse range of non-statutory providers among whose benefits is held to be 'a wider range of choice of services for the consumer"(pp.19-22) .

In 1990 the NHS & Community Care Act, based on the White Paper(1989,Cm.849) was introduced(Walker, 1993,p.216). However, new arrangements for community care were introduced on 1 April 1993(Audit Commission,1994,p.3). The central component of the new approach is the separation of responsibility for commissioning and providing services. Local authorities are clearly confirmed as the lead agencies for community care. The concept of care management is being promoted as 'the cornerstone of high quality care, whose aim is to link users' and carers' needs more directly with resources available, with providers adjusting their services to meet these needs'(Audit Commission,1992,p.1).
The Audit Commission(1993), *Taking Care: progress with care in the community*, emphasised needs-led services. 'The focus

must be on people and their needs in community care, even in the past it has been on providing effective services'(p.2). And recommended that:

"Authorities must strike a balance, creating an environment in which flexibility and imagination can flourish within a framework of sound quality and financial controls and must introduce eligibility criteria for all client groups to provide guidance to assessors and to limit their own financial liability"(p.15).

The Audit Commission(1994), *Taking stock: progress with community care*, suggested authorities should be more sensitive, flexible and responsive with services to improve a needs-led approach:

"services required to provide a framework within which individual needs can be addressed(p.6)...to introduce some flexibility within services by deploying them in different ways..and extending existing services...to make use of funds not assigned in advance to any specific service but the 'spot' purchasing of services as necessary(p.10)...To help stimulate greater choice and variety, authorities should be managing the market to ensure that any provide a wide range of options that match need"(p.22)

Post-Griffiths community care policy has increasingly emphasised an effective response to individual needs as the priority. Community care policy, as Payne(1995) analyses, individualises in two ways. First, it seeks to divide up a structure of service provision and fragment it, so each service or location becomes relatively isolated and in some ways is in competition with other services. Second, services are supposed to be organised round the person who needs them, rather than based on a set range of services(p.47). However, he argues that the emphasis on individualisation supplies the political ideology behind increasing private and independent sectors involvement in providing community care(p.33).

# FACTORS AFFECTING THE DEVELOPMENT OF COMMUNITY CARE FOR ELDERLY PEOPLE

Community care has developed into a variegated mass of professional, voluntary and informal care systems and non-systems. It has been promoted by governments at national and local level as an adjunct and sometimes a substitute for formal social and health services(Johnson & Challis,1983, p.96). There is a tendency that political/economic aims, which emphasise 'economic efficiency in the supply of services rather than better quality of services, have always taken precedence over any wish to improve community care for elderly people'(Jamieson,1991,p.291). Although political/ economic factors may be key inspirations behind the development of community care, other important factors can be identified.

## Socio-demographic factors

Finding ways of providing community care has become a central concern in the care of most social and health care user groups. In the case of elderly people, the rapid growth in size as well as dependency of the population has increasingly directed attention towards the maintenance and extension of community support(Challis & Davies,1986,p.1). Changes in the population structure are among the most powerful influences on policy-making and on whether or not policies can be put into practice successfully. Two main demographic developments, according to Walker(1982), have influenced community care for elderly people in the UK. The one is concern about the so-called 'rising tide' of elderly people in the population. The other is the number of potential caregivers who might take on responsibility for providing care services on an informal basis(pp.6-7).

As seen in table 3-2, from the 1970's to the 1990's the elderly population(65+) increased from about 7,056m to about 7,859m. This represents more than 15% of the total population in England and Wales. Within the elderly group those aged 75 and over grew from about 2.5m to 3.2m. Not only has the elderly population already increased but it is anticipated that it will continue to increase although at a slower rate and will reach over 7.2m by the year 2001.

Table 3-2: Projected change in elderly population in England and Wales(1976-2001) Thousands(%)

| Age group/Year | 1976 | 1981 | 1991 | 2001 |
|---|---|---|---|---|
| 65-74 | 4,519(9.2) | 4,549(9.3) | 4,357(8.7) | 3,962(7.8) |
| 74+ | 2,546(5.2) | 2,849(5.9) | 3,232(6.6) | 3,302(7.2) |
| Total | 7,056(14.4) | 7,395(15.1) | 7,589(15.9) | 7,246(15.0) |

Source: Personal Social Service Council, 1992; Lim,1995,p.29

This significant increase in the age 75 and over group has already presented a major challenge to health and personal social services because there is a close association between advanced old age and disability(Townsend,1979;Qureshi & Walker, 1986,p.110). For example, the proportion of elderly people who are unable to go out of doors and walk down the road unaided increases ninefold between the 65-69 and the 85 and over age group(Goddard & Savage,1991,p.24). Another example is that those aged 75-79 are about six times more likely than those in the 65-69 age group to have a local authority home help(Goddard & Savage,1991,p.47).

Phrased in a slightly different way, the majority of elderly people are female, and with increasing age, the sex ratio becomes increasingly skewed. This is due to differential life expectancy(Wicks,1982,p.99) - women can expect to live a further 18 years, but men 13 years, after their 60th birthdays - and so three-fifths of all elderly people are

women. Over the age of 75 there were twice as many women(2,283,000) as men(1,1173,000)in 1988(OPCS,1991,p.29). The change in the age structure of population is partly due to changes in the birth rates. The beginning of the 20th century, as shown in table 3-3, saw an increase in the birth rate, until the end of first world war. The people who were born at the beginning of the 20th century have become the most frequent users of social services. Also there has been a slight increase in the expectation of life at old age(DHSS, 1978, p.7).

Table 3-3: Average annual changes of birth in the UK (1901-1994) Thousands

| Year | 1901-11 | 1931-51 | 1951-61 | 1971-81 | 1991-94 |
|---|---|---|---|---|---|
| Average number | 1091 | 793 | 839 | 736 | 773 |

Source: CSO(1996), Annual Abstract of Statistics, London, HMSO

However, the population of carers is anxious about changes in the potential supply of people to provide informal care in community care. Most importantly, as Walker(1993) argues, there is the fertility trend towards smaller household size(see table 3-4). This means that by far the main source of the informal care basis for elderly people in need is facing the increasing prospect of caring for longer and with fewer potential family members to help(p.311).

Table 3-4: Average household size in Great Britain 1971-1993 Persons

| Size/year | 1971 | 1981 | 1987 | 1991 | 1993 |
|---|---|---|---|---|---|
| Persons | 2.91 | 2.70 | 2.55 | 2.48 | 2.44 |

Source: OPCS(1993), General Household Survey, London,OPCS.

The trend towards increased female participation in the

labour market puts additional burdens on the informal care sector in which women predominate in community care(Walker, 1993,p.312). The Social Services Committee Report(1990) on community care and carers remarks: 'perhaps the largest single factor which may affect informal care in the future is the level of participation of women in the labour market'(Laczko & Noden,1991,p.32).

It is difficult to find clear evidence that women are giving up informal care of elderly people for entry to the labour market in the UK. However, some indications of potential conflict can be presumed between paid work and elderly people caring. Parker(1989) purses this line of analysis:

"When female carers already have another job, that of paid worker in the labour market, it may be more difficult for them to acknowledge elderly people caring as 'another job' because to do so would also be to acknowledge the inevitable conflict between their respective demands"(P.543).

As presented in table 3-5, 8,788,000 of women in 1971 in the UK were employed. By the end of 1994 this had risen to 11,657,000. Women's participation in the labour market, particularly that of married women, has increased sharply over the last 25 years.

Table 3-5: Women(16+) in employment in the UK(1971-1995)

Thousands, %

| Year | 1971 | 1975 | 1981 | 1985 | 1991 | 1994 |
|---|---|---|---|---|---|---|
| Number of employment | 8,788 | 9,563 | 9,761 | 10,275 | 11,671 | 11,657 |
| | | | Percentage economically active | | | |
| Non-married | 45 | 42 | 44 | 45 | 46 | 45 |
| Married | 44 | 51 | 51 | 51 | 59 | 60 |

Source: CSO(1996), Annual Abstract of Statistics, London, HMSO
OPCS(1996, 80),General Household Survey, London, HMSO

According to the statistics, 44 percent of married women were

in paid employment in the early 1970s. However, by the middle of 1990s, the figures reached 60 percent. Demographic trends show the reason why the proportion of women in employment has sharply increased. As a result of a continuous decline in fertility since 1945, the number of young people entering the labour market has dropped. Consequently, recruitment has been targeted at women to return to work after time spent on child care, those women in the prime age group of 45-54(Laczko & Noden,1991,p.32). According to Evandrou's work(1991), the similar range of age group(45-59), compared with the result of Laczko & Noden's research, has important implications for the supply of informal carers when people are most likely to provide informal care for frail elderly people(p.4).
The growth in divorce and family break-ups is also one of the important influential factors in community care for elderly people(Qureshi & Walker,1986,p.112). Divorce and subsequent remarriage have increased substantially in the past 30 years in the UK(see table 3-6).

Table 3-6: Number of divorce couples in the UK (1961-1995) Thousands

| Year | 1961 | 1971 | 1981 | 1991 | 1995 |
|---|---|---|---|---|---|
| Divorce couples | 25.5 | 74.4 | 145.7 | 158.7 | 155.5 |
| 2nd or later marriage | 1.9 | 5.2 | 18.1 | 29.0 | 30.4 |

Source: OPCS(1996),Population Trends, London, HMSO.

Though the impact of this on their capacity to care, as Wicks' argues(1982), is not clear, this may lead to 'a blurring or confusing of the lines of responsibility for the care of elderly parents, step-parents and so on'(p.108). Cicirelli(1983) maintains that there is evidence that divorced adult children give less help to their parents than

those in stable marriages. As well as providing less direct personal care they are less likely to have social contact with their older relatives(p.623).
All these changes are potentially worrying if the bulk of help and support for people with special needs should be provided by their immediate families.

## Political & Economic factors

Political and economic factors affecting community care(see chapter two) have also been changing, some equally rapidly. In the UK economic concern about the cost implications of welfare spending for the elderly population - in terms of pensions, health and social services - is coupled with political worries about the fiscal implications of increased welfare spending (Walker, 1993,p.313).

Table 3-7: Total benefit paid to the elderly in total expenditure and retirement pension(79/80-1993/94 £ million,(%)

| Section/Year | 79/80 | 84/85 | 90/91 | 91/92 | 92/93 | 93/94 |
|---|---|---|---|---|---|---|
| Total benefit expenditure | 18,777 | 38,252 | 56,241 | 56,309 | 74,743 | 80,943 |
| Total benefit paid to the elderly | 10,138 | 18,522 | 28,584 | 31,339 | 34,398 | 36,763 |
| | (54.0) | (48.4) | (50.8) | (48.0) | (46.0) | (45.4) |
| Retirement pension | | 15,516 | 22,725 | 25,712 | 27,060 | 28,352 |

Source: DSS(1994),Social Security Statistics, London, HMSO
CSO(1996),Annual Abstract of Statistics, London, HMSO

The table 3-7, reproduced from the social security statistics, shows that total benefits paid to elderly people as part of the total benefit expenditure has been increased from £10,138m in 1979/80 to £36,763m in 1993/94. In the case

of the expenditure on retirement pensions, the figure almost doubled during the decade 1984/85 and 1993/94.

The services implications of political/economic pressures are a cost-effectiveness imperative that, for example, establishes the principle that elderly people should stay in their homes for as long as possible. It promotes a search for cheaper forms of care(walker,1993,p.313). Whilst the concept of community care is attractive to those who have the interests of elderly people at heart, there is no doubt that the expectation that it is cheaper than institutional care has made it popular among policy makers, whatever their political persuasion(Jamieson,1991,p.289). As mentioned earlier, Scull maintains the same line of argument, that economic factors are the main influences on the development of community care:

"that the growing cost of institutional provision has been a factor in the growing emphasis of governments in arguing for a need to switch resources from institutional provision to the development of domiciliary services in the community" (Scull,1977;Goodwin,1990;Means & Smith,1994, p.38).

According to Walker(1982,p.7), Challis & Davies(1980) present some statistical evidence on this argument concerning the rise in the cost of residential care. Between 1957 and 1979 the gross unit cost of elderly people's homes rose by two-fifths and the net costs by three-fifths.

Whether the direction of changes promotes community care for elderly people is another question and depends on prevailing political priorities and beliefs(Jamieson,1991, p.291). The trends towards privatisation and residualization in community care, which is most clearly linked with the wish to replace public-sector care with markets and the informal sector, can be understood as a political move(see the previous section), guided by neo-liberalist ideas rather than by clear evidence

that such changes will improve the quality and distribution of services(ibid).

## Preference of elderly people & Grassroots pressures

### *Preference of elderly people and anti-institutionalisation*

It is perhaps appropriate to start with the elderly person himself/herself and what their preferences are. Common knowledge and research have combined to produce the view that elderly people prefer to be in their own homes if they are provided proper care services or cared for by their own kith, friends and kin. This remains a tenet of belief which continues to be empirically supported(Johnson & Challis, 1983,p.96). Victor(1991) shows in a recent survey in London that elderly people favour community care as the most appropriate form of provision for them. Community care is favoured because it maintains and provides independence (54%), better quality of life(21%), and familiarity with the area(11%)(p.264). Tinker(1976) also found out in 'a survey of Granny Annexes' that older people wished to be independent and live in a mixed community, giving as reasons that they liked to see children and younger people. They disliked being solely with their own age group(p.28). A constant theme running through all the comments of elderly people in the survey was that: 'It's my own little place,.. It is all to myself,.. and I 've got my own front door'(p.21). This trend - the preferences of elderly people - has combined with a long standing critique of institutional care to encourage community care (Walker, 1982,p.8). As mentioned earlier, there have been powerful social arguments against

institutional care since the late 1950s. A number of studies have demonstrated the shortcomings and social inadequacies of institutional care for elderly people(Wicks, 1982,p.111). Most significant was Peter Townsend's work(1962,p.430), *The Last Refuge*, which concluded that:

"Communal homes of a kind which exist in England and Wales today do not adequately meet the physical, psychological and social needs of the elderly people living in them,..alternative services and living arrangements should quickly take their place".

In a study into short-term institutional care, Allen(1983) reported that a substantial minority of the residents found the apathy and inertia around them very distressing and stated that there was little enthusiasm among the short stay residents for a permanent move to the institution(p.172). More recently, Willcocks et al.(1987) have chronicled in detail the quality of life of elderly people living in communal settings and have attempted to describe how 'independent living' can be promoted(Victor,1991,p.262). Clough also found a lack of choice and privacy for residents in residential homes. He was especially critical of the lack of positive choice on entering into homes(Clough,1981;ibid). A body of research has also demonstrated that for many elderly people, admission to an Old People's Home rests on social factors such as the lack of alternative forms of care, rather than simply physical or mental disability (Townsend, 1965; Walker,1987,p.375). Neglect within institutions can be understood to generate a negative image to those who are outside their walls. This negative image can help to persuade people that there should be increased public expenditure on benefits, health and social care services to enable elderly people to remain in the community with comfort(Means & Smith,1994,p.37). However, the negative image of

institutional care has became 'accepted wisdom' within policy circles, which is concerned as much with cost containment as with the 'human' care of elderly people (Victor,1991,p.264). For once, economic as well as other social factors point in the direction which is indicated by elderly people's preference. The powerful social and economic considerations point towards the same objective: 'to enable older people to maintain independent lives in the community for as long as possible'(DHSS,1978,p.32).
Along with the economic and social considerations, we need to pay attention to the needs expressed and felt by carers, especially female carers.

*The feminist critique*

Since the late 1970s, feminist researchers have been engaged in a sustained critique of government policies on community care, speaking out against the orthodoxy that communities should be the major source of care for elderly people with long-term needs for support(Graham,1993,p.124). In particular, they have argued that 'community care equals care by the family, and in practice care by the family equals care by women'(Finch & Groves,1980,p.494). Therefore, community care relies on the unpaid or low paid services of women (Walker,1993,p.315). The feminist case is put by Walker (1982,p.23):

"Care is socially divided between the state and the family and between family members. In practice 'community care' is overwhelmingly care by kin, especially female kin, not community".

It is argued the provision of community care for elderly people is allocated in a way which reflects assumptions about

the availability of help from female relatives (Land, 1978, p.268). Therefore, community care policies may be subjected to the same feminist critique as traditional social services (Walker, 1993,p.315). The feminists' fundamental criticism is that community care exploits traditional attitudes which allocate the primary responsibility for caring for elderly people to female family members. Finch & Groves(1980) support this:

"Community care policies can very easily become policies which create a moral imperative to care, imposed upon women to whom nature and chance have assigned a frail or handicapped relative" (p.503).

Some examples of inevitable restrictions on types on employment for women in the labour market were given by Land(1978): 'first, they must find employment near home and second, they are less likely than men to move in order to enhance their employment opportunities'(p.281).
The conflicting demands of caring for elderly people and employment can put carers at a disadvantage in comparison with their colleagues. The acceptance of domestic limitations may mean that the carer is regarded as having a lesser commitment to her work than her colleagues (EOC,1982,p.6). Feminists and others(for example, Finch,1984 & Parker,1985) argue about another aspect of women's disadvantage, that women are disadvantaged both as carers and as recipients because women receive less support from statutory services than men(Arber et al.,1988,p.154). However, Arber et al.(1988)'s research on gender, household composition and receipt of domiciliary services by elderly disabled people suggests a different view. They conclude that evidence of discrimination results primarily in types of household and the marital status of the carer, rather than the gender of

the carer(p.171).

Despite the social and economic restrictions experienced by female carers, there is little doubt that for many female carers the emotional rewards of caring for their elderly relatives far outweigh the disadvantages(EOC,1982,p.7).

### *Complaints about bureaucratic organisations and professions*

More and more users of the social services have been 'complaining about the bureaucratic organisation, complexity and lack of responsiveness to felt needs' (Walker, 1987, p.375). This problem of bureaucratic complexity was increased, and professionalization of the social services encouraged by the expansion of the social services and development of more rigid and hierarchical management structures(Seebohm Committee,1968; Walker,1987, p.376). Some say that large bureaucracies cannot provide the variety, choice and innovative service that are needed. It is a frequent criticism that public services exist for their employees rather than for service users(Ovretveit, 1993,p.37).

Some groups of users have formed self-advocacy movements to press their case for greater influence over their own lives and the services they use. At the present time groups of elderly people are not at the forefront of pressure for change in the social services, but the strengthening of wide organisations of elderly people suggests that this may change in the future(Walker,1993,p.315)(see chapter 5).

## CARE MANAGERS AND CARE MANAGEMENT: AN EFFECTIVE APPROACH TO COMMUNITY CARE FOR ELDERLY PEOPLE IN THE UK

Within the diverse pattern of provision of care for elderly people in the UK, a major area of concern has been the extensiveness of community care. This, as discussed in the previous sections, has mainly reflected the response to rising costs for care and service user preferences . A range of services for elderly people has developed in community care, which is delivered by a variety of professionals and administered within different organisations. This has resulted in the issues of co-ordinating to meet the individual needs of the elderly clients and cost effectiveness(Dant & Gearing, 1990,p.331). Care management has been described as the cornerstone of the new UK community care policy to solve these problems(Secretary of State for England, Scotland and Wales,1989;Challis, 1993, p.79).
But certain questions have to be addressed: How has care management created the opportunity for greater flexibility of resources; What kinds of care strategies are appropriate for elderly people in different circumstances; What are the effects of the schemes for elderly clients and carers as compared with those of the usual range of services ? With the purpose of answering these points, the roles of care managers and key components of care management are discussed in the first half of this section. In the second half, care management projects are considered, followed by a discussion of some implications of UK care management experience in the transition to community care from family care for elderly people in Korea.

## Roles of care managers in care management

The purpose of this subsection is to reframe a care manager's roles at the client's level. The care manager can assume several different roles, 'designed to increase the effectiveness of the care management process itself by enhancing the client's capacities to fulfil his/her own needs'; and a care manager's role at the system-level, which involves a care manager in changing the behaviour or performance of a system on behalf of the clients(Moxley,1989,p.79).

There are different implications regarding what are the most suitable roles for a care manager. In a simple managerial model, a care manager might be recruited from relatively inexperienced or non-professional staff. A more clinical model would require experienced, highly trained professionals (see models of care management in chapter two). The issue of which professional is best placed to develop roles as a care manager is complicated, since a care manager often works with people who have multiple needs(Moxley, 1989,p.79). Therefore, a care manager's roles combine elements of many different professions in two dimensions - a role at the client's-level such as social work, nursing, psychiatry, occupational therapy, etc. and roles at the system-level, when 'a care manager must understand how the agency and the environmental systems can both positively and negatively affect clients and how to intervene to optimize conditions'(Brenna & Kaplan, 1993,p.220). Activities can include resource development, agency policy information, social action, program evaluation, and quality assurance(Brenna & Kaplan, 1993,p.220). However,

specifying the particular roles as care managers is a complicate task, although 'great care is often taken to define the scope of activities that a care manager can be engaged in'(Caragonne, 1979; Intagliate, 1982, p.659). Furthermore, according to Hughes(1995,p.94), Orme & Glastonbury(1993) argued that 'there has been considerable debate as to whether the care manager's role is new and certainly it demands many of the skills traditionally associated with most of the professionals', for example interpersonal skills and task centred practice, involved in care provision.

As to client's-level roles, care management begins once the client has been identified and engaged(Brennan & Kaplan, 1993,p.220). It is implied that each role varies according to how much a care manager exercise direction and how much self-direction is exercised by clients. Care manager's roles include three key components: an implementer/a collaborator; an instructor/a counsellor; and an administrator/an information specialist. On the other hand, at a system-level, a care manager makes use of activities and interventions 'which are implemented with a system external to the clients, as a means of operationalizing the system plan, as a means of building the capacities of systems to respond to the need of clients'(Steinberg & Cater,1983; Moxley,1989,p.94). Care management may be operated as a strategy for coordinating the service resources to clients within that system(Lievin & Fleming,1985; Rothman,1992,p.15). Reframing in this area can include the care manager as a linkman, a co-ordinater, and a broker/an advocator.

*The client's-level roles*

**Care manager as a collaborator/an implementer.**

According to Rothman(1992,p.20), an essential aspect of the success of care management is that 'a care manager should actively support the clients in actually connecting with service'(see inter-agency models in chapter two). The care manager works with the clients in identifying the services that the clients require to fulfill their needs, and then implements services to the clients through the process of obtaining these services and supports (Moxley,1989,p.87). The care manager as a collaborator usually means that there has been an agreement about the need for several practitioners and agencies to be involved. The care manager as a collaborator usually provides some services directly as part of the care package (Hughes,1995,p.95). In working as an implementer, the care manager makes use of crisis intervention techniques to establish a stable situation for the clients. To achieve this, the care manager implements several activities, such as environmental modification, psychological support, and cognitive restoration (Moxley, 1989, p.84). As Intagliate argued(1982), the need for this type of support is particularly critical for those clients whose abilities to cope with living stress are impaired or deficient. However, the care manager need not be expected to take one role as therapist or to assist their clients directly in solving the crisis. Instead, it may be more appropriate for them to refer or accompany the clients to a collaborative intervention team of an agency(p.661).
There are several reasons why clarifying the roles is an

important task for the care manager. A care manager forms a collaborative relationship with the clients in which the care manager is directly involved in the process of obtaining services and supports. Secondly, successful execution of the role encourages the clients to develop problem-solving skills. Finally, the care manager can model ways for the clients to work with providers(Moxley, 1989,p.87).

**Care manager as an instructor/a counsellor**

The role of a care manager involves direct service provision such as supporting, counselling, interpersonal or medical therapy(Hughes,1995,p.95). It means that a care manager has responsibility for a case and is responsible for providing specialist professional services. It is not unusual for a care manager to work directly with the clients in developing skills and counselling which are useful to the clients in subsequently fulfilling their own needs(Goldstein et al,1980;Moxley,1989, p.85). A care manager operationalizes the role of an instructor/ a counsellor when the clients are able to exercise a high level of self-direction. The clients develop problem-solving skills, which support effective decision-making that influences the realization of self-advocacy through instructing and counselling (see brokerage /advocacy model in chapter two)). However, Lewis et al.(1997) argue that counselling, a providing task, has to remain part of the care manager's work with clients or else the care manager's role risks becoming overly administrative(p.12). This task involves reality testing, socialization skills, and practice help(Rothman, 1991,p. 525). The utilization of a behavioural approach has been highly useful in instructing

problem-solving skills as means to securing empowerment and choice. Techniques include sharing, which is breaking down tasks into smaller increments, positive reinforcement, modelling, and role playing(Liberman & Phipps, 1984; Rothman, 1992,p.22). In transfer of training, it is important for the care manager and the clients to make arrangements for the clients to practice and use the acquired skills in real-life settings(Moxley,1989, p.86). The essence of the role of an instructor/a counsellor is that the care manager supports the self-advocacy of the clients and the movement of the clients towards higher levels of self-direction(empowerment) (Moxley,1989,p.91).

**Care manager as an administrator/an information specialist**

The most basic role that must be played by a care manager in any system is to remain aware of the comprehensive needs of the clients(see administrative model in chapter two). This means that a care manager must be aware of, though not necessary directly involved in, the initial intake and assessment of their clients (Intagliate,1982,p.659). The care manager as an administrator organize and leads teams of professionals in care decision-making, and planning the delivery of clients' services (Moxley,1989, p.144). It means that the care manager occupies a central position within complex information and service delivery networks. Therefore, the care manager requires to have considerable information and knowledge about community resources and what is required to access these resources(Moxley,1989,p.89). The care manager as an administrator ought to develop procedures 'that are flexible enough to accommodate individual needs, to promote more user friendly information sharing, and accelerate the

development of the necessary information systems'(DoH,1991, p.31). Under the new arrangements, the care manager has either indirect knowledge of, or direct responsibility for, the budget within which care must be provided(Hughes, 1995,p.95). The responsibility for budget and resource allocation is the catalyst for more flexible services which better meet the needs of the clients(see decentralized budgetary contol model in chapter two). This role evolves out of a care manager's specialised knowledge of social services, benefit systems, and opportunities available to his/her clients within the community. As in an administrative role, the care manager places an emphasis on serving as a technical agent who enables the client to build their knowledge about fulfilling particular needs. In the role of information specialist, the care manager is not very intrusive. Rather, the care manager is concerned about 'whether clients have sufficient information to fulfill their needs through the best resources available'(Moxley, 1989, p.91)

To sum up, in the client's-level role, a care manager provides a means of building and strengthening the self-care capacities of clients. However, client's-level intervention, according to Moxley(1989,p.91), is not the only means of providing services to a client. Environmental intervention also is an important component of care management. Therefore, the community care system and social networks are legitimate targets of the intervention armamentarium of a care manager.

*The system-level roles*

**Care manager as a linkman**

Linkage is a strategy used by a care manager to connect the

clients to the services available in order to assure utilization. Implicit in the role is a need to liaise with other professionals and informal carers to provide a human linkage between the clients and a range of the services social networks(Hughes,1995,p.95). One of the principal means of linkage is referral(Hepworth & Larsen, 1982; O'Neil,1984; Weissman,1976; Moxley,1989,p.98). Effective referral is a complex process that involves a care manger in conducting mediation work between the clients and then identifying the services or social networks. There may be barriers that inhibit clients from receiving services. Potential barriers include service agencies' restrictive regulations and policies or the reluctance of many generic providers to service clients with particular disabilities. In addition, it is sometimes the clients themselves who resist being served or drop out of service(Intagliate,1982, p.660). The ability of a care manager to fulfill successfully the linkage role may be related to the extent to which 'the local authority is willing to purchase services for clients and the extent to which services must be obtained without meeting the costs of the agency'(Hagen, 1994,p.202). As Rothman(1991) argued, linkage requires the use of organizational skills(eg.who makes a contact and at what level) and community-oriented skills(eg.what new services are developing, what legislative policies are applicable, and what funding is available) to optimize service connections(p.521).

**Care manager as a co-ordinater**

Care management is designed to enhance coordinated service delivery(see origin of care management in chapter two) to

assure that services are being implemented in 'harmonious and compatible ways by the social service providers and social network members who have been organized by a care manager to respond to the clients' needs'(Moxley,1989,p.101). Awareness of local resources makes the care manager an authority on service gaps and overlaps that exist in a community. The care manager strives to reduce the service duplication that can occur when multiple providers each prepare separate care plans for the same clients(Applebaum & Austin,1990,p.9). However, as Moxley argued, there are several barriers to accomplishing effective coordination of client service and supports. The agencies involved in the effort may perceive a lack of shared interests(Zald, 1979; Moxley,1989,p.101). They are in competition over access to the very client around which the care manager is asking them to cooperate(Apolloni & Cooke,1984; Moxley,1989,p.101). Coordination of client service delivery turns on the important role of the care manager as an organizational boundary-spanner. The care manager can make a contribution to strengthening the responsiveness of agencies to client needs by fulfilling effective co-ordinator's roles. For example, the purchasers/providers separation, which is accompanied by a number of challenges to the multi-agency care coordination model, provides an opportunity to devise an effective role for the care manager as a coordinator. However, there is the fear that a firm purchasers/providers split would have the effect of creating a more administrative role for the care manager(Lewis et al.,1997,p.15). The care manager can serve the development of new services and programs designed to fulfill unmet client needs by introducing new knowledge, information, and perspectives into social service agencies

as a means of improving services co-ordination (Gallessich,1982; Moxley, 1989, p.110). To execute this strategy the care manager relies on education and the exchange of knowledge(ibid,p.112).

**Care manager as a broker/an advocator**

Service brokering describes 'an approach in which advocacy with and on behalf of the service users is to the fore' (Hughes, 1995,p.96). The care manager's key role involves selecting appropriate agencies or community resources which can deliver the services identified in the best package of service or a support plan(see brokerage/advocacy model in chapter two). This strategy is used by the care manager to connect a client to a resource that can appropriately and adequately address the needs of that client. Because social service delivery systems are complex for lay people who have inadequate knowledge and information about available services (Moxley,1989,p.96). Effective brokering, according to Moxley(1989), depends on the care manager's knowledge of the social service delivery system within a particular community. Another factor influencing effective brokering is the care manager's liaison experience with other agencies(p.97). Through liaison relationships the care manager can include other service providers as members of the interdisciplinary team that constructs the client service and support plan(see Darlington project in the following subsection). Care managers can access other agencies through the professional networks of their colleges. In the course of trying to ensure that clients receive continuity of care, it is inevitable that the care manager will identify gaps in the service

system. In other words, 'the system to which they attempt brokering for their clients is likely to be incomplete' (Intagliate,1982,p.662). Through advocacy activities the care manager attempts to correct an injustice that evolves out of the denial of services. Thus, according to Moxley, case advocacy is an appropriate intervention strategy when a social service is rigid and unwilling to meet the needs of an identified clients or group of clients(Johnson & Rubin, 1983; Moxley,1989,p.105).

To sum up, care management is a complex function. If effective continuity of care is to be provided for clients, coordination must take place at many levels within the system. Among the many possible structural elements that could be developed to implement care management, two have been specified as essential. The first is the care manager who provides coordination and integration of services at the client's-level. The second is at the systems-level' which is responsible for coordination and linkage of programs.

## Key Components of care management in community care

There is a clear view that care management should be defined as any process of managing services for the individual user in a way that can provide continuity of care and accountability to user and agency(see care management in chapter two). Despite the different models and approaches to implementing managed care, care management has a common set of core components. According to the White Paper, *Caring for People(Cm.849)*(DoH,1989), it comprises five core tasks that would be undertaken for all users to varying degrees and in different ways: identification of people in need; assessment

of care needs; planning and securing the delivery of care services; monitoring the quality of care provided, and a review of client needs(pp.18-22). These core components, which are most commonly considered, are parallel to the key tasks identified by Challis and Davies(1986), such as case finding, assessment, care planning and service arrangement, and monitoring and reassessment (Lewis et al,1997,p.7).

*Case finding/Screening*

Case finding and screening is the initial process of identifying potential clients in greatest need(Cameron & Freeman,1996,p.93) through referrals or other means, for example nursing home application and public information campaigns. Case finding activities reflect the targeting requirement of the care management program and thus represent the first step toward reaching the program's target population and criteria (Applebaum & Austin,1986,p.18). They are assessed as to 'whether they are able, or would wish, to benefit from community care and then become part of the care management process'(Orme & Glastonbury, 1993,p.68).
A major difficulty, as Cambridge argues(1992,p.499), is refining or narrowing targeting criteria to enable selection of clients. Projects for elderly people employed explicit targeting criteria in the UK. Winchester employed explicit targeting criteria, concentrating on frail people without confusion who were in hospital because of the lack of a full-time informal carer. Darlington sought to rehabilitate people who were described as physically handicapped but mentally alert, only those who were totally immobile or relatively confused were deemed to be ineligible for the service

established. Camberwell and St.Helen focused upon elderly people 'not requiring nursing levels of care'(Knapp et al.,1992,p.209). However, Orme & Glastonbury(1993) argued the issue is 'whether such work needs to be done by a specialist team which has responsibility for identifying needs and involves social work skills or whether such marketing techniques will be taken on at management level'(p.71).
Screening is a preliminary assessment of clients' circumstances and resources that is done to determine presumptive eligibility and appropriateness for a care management program(Applebaum & Austin,1990,p.18). As with the screening process, it is necessary to acquire a certain amount of information and become involved with the individual before even initial service decisions can be made(Orme & Glastonbury,1993,p.71). There is variability in the screening process in the UK, mainly reflecting the mix of agencies and professional work together. The Islington scheme had to dispatch project workers to find potential clients and match them against the criteria of the project. In Brent the rehabilitation coordinator liaised closely with the project manager, with multidisciplinary referral information built around common documentation(Cambridge, 1992,p.499). In Somerset, staff from health and social services met as integrated hospital review groups to coordinate referral. Being health authority-led, the Winchester project required less inter-agency liaison, although clients were initially identified by the project coordinator who required reports from hospital social workers as well as consultants and ward staff. A committee was responsible for choosing clients from a preselected pool of clients in Warrington. In West Cumbria, the project officer and officer-in-charge were involved in

case finding, referral and selection which helped coordinate the whole process(Knapp et al., 1992,p.210).
A critical aspect of both case finding and screening, whatever the background of the potential user, is to have full information about the agency's policy. *Caring For People*(Audit Commission, 1989) specifies that 'the means of case finding/screening should be the criteria for eligibility for assessment'(para.3.2.9). A number of factors are relevant to criteria: organisational locus, initial agency contacts and procedures(Challis & Davies,1986,p.39). However, Knapp et al.(1992,p.210) argues that no definitive model for case finding and screening emerged from the programme in the UK, even though the key elements of this core task of care management are illustrated.

*Assessment*

Assessment is the scheduled effort to develop information about clients' medical, functional, social and emotional status, and service needs. Multidimensional assessment may be part of eligibility determination and setting a baseline (Capitman et al.,1986,p.400). It means that decisions are made about the level of service involvement and the nature of that involvement(Orme & Glastonbury,1993,p.72). However, without clarity in targeting criteria or client outcome goals, it is difficult to service access and considerations of equity. The distinction between simple and comprehensive assessment identified in the guidance documents (DoH, 1991, P.43) was largely irrelevant to the UK projects as they worked with long-term needs groups; so assessment fell at the comprehensive end of the continuum, throwing up some complex

problems(Cambridge,1992,p.500). Standard instruments, according to Knapp et al.(1992), are most often used in the assessment process(p.211). Some projects proposed named assessment instruments in their applications for funding, and most also indicated an intention to use some level of multidisciplinary assessment for identification and selection, either by multidisciplinary teams or special task-oriented groups such as core teams(Bolton & Camberwell), selection panels (Isington) or hospital evaluation teams (Somerset)(Cambridge, 1992,p.500). A few projects used semistructured assessment techniques such as case notes or reports(Chichester), information sheets(Camden), ration sheets and getting-to-know-you techniques(Warrington) or information extracted from existing ward assessments (Kidderminister and Warwick)(Knapp et al.,1992, p.216).
It is important to stress that assessment is not a single event, but an ongoing process which is often time consuming, and it is the process which is evaluated(Cameron & Freeman,1996, p.94). The issues are complex not least because assessment is concerned not only with the needs of elderly people but also their strengths and the identification of obstacles to achieving change(Challis & Davies,1986,p.44). For example, in some projects, hospital surveys of dependency and other information were conducted in this multi-stage filtering process(Darlington, Somerset). However, the most important assessment tool is the well qualified worker who brings to the process skills to do with interviewing techniques. These techniques are informed both by training and by the ability to understand the perceptions and experiences of the participants in the process(Steinberg & Carter,1983; Orme & Glastonbury,1993, p.75).

*Care planing and service packaging*

Care planning is 'the process of developing a plan for caring for the client that identifies the services to be delivered and the frequency, duration, and goals of these services' (Capitman et al.,1986, p.400) translated into a package of services (Schneider,1988; Applebaum & Austin,1990,p.22). This stage marks the crucial link between large-scale service planning and individual client assessment. Care planning can be performed by a single care manager or by team care planning conferences. Most organised care planning is on a team basis in the UK, like a resettlement team(Kidderminster) or community rehabilitation team(Chichester), and joint care planning teams(Torbay). The care planning function in the Darlington and Chichester projects was completed by a multi-disciplinarary team member who typically possessed either professional or advanced professional degrees(Knapp et al,1992,p.220). Where there are many different professional inputs and agencies likely to be involved, care planning provides the opportunity for coordination of action(Jenkins et al,1988; Cambridge ,1992,p.502).

Involvement of clients' informal caregivers is an essential part of the care planning process. The goal is to negotiate feasible informal support in combination with formally provided services(Applebaum & Austin,1990,p.23). However, a key issue is whether the care plans are systematically costed out or not. Care managers operating within specific budgetary limits must be able to judge when a client's community or home care plan will exceed the cost of providing a comparable level of care in nursing home or hospital. Care managers'

skill in making these choices and estimates is an important factor in controlling long-term care costs(Rickard;Applebaum & Austin,1990).

Service packaging is the process of contracting service providers, the client, and informal caregivers to arrange for care plan implementation. This includes processing referral forms, working with providers to assure service availability, locating other providers, and developing substitute services when necessary (Capitman et al.,1986,p.400). Care packaging also distributes resource to providers in the local delivery system. A key aspect of care packaging involves sharing client assessment and care plan information with all relevant informal and formal providers (Applebaum & Austin,1990,p.24).

*Monitoring & Reassessment*

Monitoring and reassessment of intervention is an ongoing part of care management because services are needed on a continuous and indeterminate basis(Wolkon et al.,1978; Sherman, 1989; Rothman, 1992, p.23). Four purposes of monitoring in care management, according to Moxley,(1989): 'it determines the extent to which the service plan is being implemented appropriately'; 'it determines achievement of the objectives of the client service and support plan'; 'it determines service and support outcomes'; 'it identifies the emergence of new client needs requiring change in the service plan'(pp.115-116). Monitoring is a critical care management task that enables the care manager to respond quickly to any change in the client's status. The frequency of monitoring varies depending on the intensity of client needs and the type of services being delivered(Applebaum & Austin, 1990,

p.24). Six-monthly case reviews were the norm, which is much more regular than is generally to be found in local authorities. However, The Audit Commission(1989), *Caring for People*, found that over half of all local authorities conducted annual reviews(p.x). In the projects with less frequent formal case reviews, supplementation came from regular informal monitoring. Reviews were held only when needed(Maidstone). Ongoing assessment was tied in with six-weekly reviews and formal annual reviews(Somerset), an annual coordinating review by social services staff(Warwick), and combinations of frequent informal reviews and occasional formal assessment(Waltham Forest & Coventry)(Knapp et al.,1992,p.221). The care manager has a choice in structuring the monitoring function. Considerations such as time, technology, size of caseload, and breadth of responsibilities must be taken into consideration when choosing the form, the tools, and the techniques of monitoring. Each dimension of monitoring requires awareness of the effort involved, and adequacy, quality, and outcome(Moxley, 1989, p.117). However, there is an issue of the level of staff professionalization in monitoring.

Reassessment takes place by the scheduled examination of the client's situation, and functions to identify changes of their lives which occurred since the initial or most recent assessment, and to measure progress toward the desired outcomes outlined in the care plan(Cambridge,1992,p.502). Reassessment can be formal or informal, periodic or ongoing, and can occur at various intervals of frequency (Rothman, 1991,p.525). However, Applebaum & Austin (1990) argue that 'reassessment can be triggered by other events once the initial problem has been solved, alleviated, or

refined'(p.25). It is also needed when planned services are discontinued by the service provider or the client, such as with the loss of a major caretaker through death or relocation; and death of the client's spouse or member of household(Applebaum & Austin,1990,p.25).

## Care management projects in the UK

The concept of care management has influenced the implementation of a number of innovatory schemes in the UK since the late 1970s(Dant & Gearing,1990,p.331). These schemes have displayed different emphases in service brokerage and social care entrepreneurship in which 'formal and informal care is interwoven using a variety of service inputs tailored to individual need'(Beardshaw & Towell,1990, p.18). According to Dant & Gearing(1990), these innovatory schemes have demonstrated 'the need for care management and clarified the tasks that are involved in taking responsibility for coordinating services to meet the needs of elderly people in community care'(p.331).

A series of studies of care management in the care of elderly people has been undertaken by the PSSRU at the University of Kent(see origin of care management in chapter two). The first of these was undertaken in Kent. Subsequent studies have developed the original Kent model, and involved care management for frail elderly people based on both social and health care in Gateshead and geriatric care in Darlington (Challis et al,1993,p.184). The care management models have been designed to ensure that improved performance of the core tasks of care management could contribute towards more cost-effective and efficient long-term care in the community

(Challis et al,1993,p.185).

An analysis of three UK care management projects is given in this subsection of the section. This case study enriches our understanding of what it would mean to be successful in implementing care management in community care in Korea. Important elements of general approaches are highlighted with a condensed summary of emerging key points from project evaluations, such as the roles and tasks of field workers and how these contribute to the effectiveness and efficiency of the long-term community care.

*The Kent social care scheme*

The Kent scheme was set up in the middle of the 1970s, in a retirement area in the South-East of England (Challis et al., 1990, p.19). It is perhaps the best known example of adopting the principles of care management for elderly people in the UK(Dant & Gearing,1990,p.345). The project was concerned with cost-effectiveness and social care process issues, addressing the following questions:

"What was the effect of care management service for elderly people and their carers compared with the usual range of services and what were the costs of care ? How did the team respond to the opportunity of greater flexibility and control of resources and what did the scheme indicate about the roles and tasks of field workers in long-term care ?"(Challis & Davies, 1985b,p.5).

The model of care management was based on a single designated worker acting as a care manager located within a single agency(the social service department) and performing all the core tasks of care management(Challis et al.,1990,p.10). A small team consisting of two social workers - more trained /experienced than usual in work with elderly people (Challis et al., 1993, p.186) - acting as care manager and a senior

practitioner with administrative support, were located alongside existing services in one area for this experiment (Challis,1993,p.18). The care managers with small caseloads(about 25-30)(Challis et al.,1993, p.186) not only had control over management of social services resources but had a budget with which to buy care in the form of local, paid helpers(Dant & Gearing,1990,p.346). However, the overall weekly cost of an individual package of care was limited to two-thirds of the cost of a place in a residential home. This was designed to permit more flexible responses to needs and the integration of fragmented services into a more coherent package of care to provide a realistic alternative to institutional care within an overall framework of accountability(Challis,1993, pp.81-82)(see decentralised budgetary model in chapter two). A record system, aimed at enhancing accountability and supplementing ongoing casenotes, was introduced. The records permitted summary feedbacks to be given about caseloads, the mix of client problems, and care manager activities(Challis, 1993, p.82).

*Case finding & screening:* The scheme was targeted at the most frail elderly people who needed to be placed on the margin of entry to long-term institutional care(Challis et al., 1993,p.186). These tended to be two kinds: one was people requiring a level greater than that usually provided in a residential home. The other group tended to be those elderly people suffering from functional psychiatric disorders for whom the existing service response was often inadequate (Foster et al., 1976;Challis & Davies, 1985, p.567). Referrals came mainly from an area social work team, local GPs, and community nurses(Dant & Gearing,1990,p.346). The average age was 80 years, and three quarters were women. All

experienced problems with instrumental activities of daily living. One third suffered from incontinence, one quarter from confusional states, and two thirds were at risk of falling (Challis,1993,p.82).

*Assessment:* The separation of assessment from care planning was an essential element of the philosophy of the scheme, to avoid routine service based assessments(Challis & Davies, 1985b,p.6). Assessment was concerned not only with the needs of elderly people but also their strengths and the identification of obstacles to achieving change(Challis & Davies,1986,p.43). Thus the approach was need-oriented rather than assessment of elderly people in relation to their suitability and eligibility for existing services (Challis & Davies,1985, p.567). The care managers, able to provide more varied services by virtue of their flexible budget, tended to undertake more broad-ranging assessments than before (Challis,1993,p.82).

*Care planning & care packaging:* Home helps, community nurses and helpers were the three resources most commonly used in a package of care(Challis & Chesterman,1985,p.128). The major new resource upon which the budget was deployed, in combination with the range of existing services, was the use of local people(Challis & Davies,1985,p.567) as helpers to provide care at times and in ways that existing services did not(Challis, 1993,p.82). The tasks which helpers have undertaken range from immediate practical help with tasks of daily living when other help was not available to social and therapeutic intervention. These extra care inputs were provided as part of an overall care plan, integrating the activities of several agencies, formal and informal carers

(Challis & Davies,1985,p.568).

*Monitoring:* Care managers assumed continued responsibility for clients once service packages had been established, monitoring and adjusting care when required(Challis, 1993, p.82). A simple tool was developed to aid the monitoring of what could at times be a complex network of care. This was 'a chart of a matrix with the seven days of the week on the vertical axis and critical periods of the day on the horizontal axis'(Challis & Davies, 1985b, p.9). It was noticeable that for some of the more intractable problems in care of the elderly people, which are often unresponsive to the usual range of services, additional strategies of management were developed by the team(Challis & Davies, 1985, p.569).

*Outcome:* Findings of the initial Kent study indicated that care managers with devolved budgets could significantly improve the effectiveness of social care for very frail elderly people (Challis & Davies,1986;Challis et al.,1993, p.186). A significantly higher proportion of these receiving the care management service remained at home, 69% compared with 34% of the control group(Challis & Davies,1985,p.572). A follow-up over four years found that the reduction in admission to institutional care was still greater for those receiving care management service, 23% remaining at home compared with 11% of those receiving the standard range of services(Chesterman, Challis & Davies, 1988; Challis,1993, p.82). Lower rates of institutionalisation were observed for those receiving care management, and the quality of life for both elderly people and carers improved compared with people receiving existing services. These effects appeared to

involve no greater cost than the traditional services(Challis et al.,1993,p.186). The results suggest a small cost advantage to the social services department from the community care scheme.

*The Gateshead primary health & social care scheme*

The care management approach, which originated in Kent, was further developed in Gateshead in the north-east of England, providing a basis for testing the portability of the model into an urban setting in the late 1980s(Challis et al.,1993, p.186). Despite the clear evidence of marked improvements in the care and support provided to elderly people as a result of the social care scheme in Gateshead, further progress was constrained by the complexity of the health care needs of some severely disabled elderly people, in particular incontinence, immobility and episodes of acute illness. It was considered that these difficulties could be most effectively tackled by working more closely with staff who had medical, nursing and paramedical expertise(Challis et al.,1990,p.61). Therefore, the primary health and social care scheme was launched.

Three social workers, a full-time senior nurse, a part-time junior doctor and 25% of the time of a physiotherapist were called on to complement the team, as well as additional resources to be spent on the care of elderly people in a flexible way, as in the original social care scheme. The costs of care purchased by the team were shared equally between the social and health services (Challis, 1993,p.85). Organisationally, building on the established social care scheme, the existing team leader took responsibility for team management. The staff were located within the existing

teams's office within the social services department in order to develop a team ethos(Challis et al,1990, p.62). The nurse adopted a care management role, comparable with that undertaken by the social workers, while the doctor and physiotherapist were principally concerned with the functions of assessment and monitoring. As the nurse took on the full time role of care manager, the practical nursing functions were undertaken by an existing nurse working in the community(Challis et al.,1993,p.192).

*Case finding & screening*: The cases were on the whole more dependent than their counterparts in the social care scheme. All the informal carers appeared to be stressed and experienced difficulty with key activities of daily living. A higher portion of elderly people suffered from incontinence and confusional states than on the social care scheme (Challis et al.1990,p.64). The referral sources feeding into the scheme were unrestricted. Most came from GPs and district nurses(16), the social service department (11), and others(2). The main criteria for referral included the presence of multiple health and social care needs, carers suffering stress, and the fact that home care was a possible means of enhancing quality of life for elderly people(Challis et al.,1993,p.192).

*Assessment:* Either a nurse or a social worker, acting as the care manager, would make the first visit, often depending on the major presenting problem, and over a period of up to six weeks the elderly people would be seen by each member of the team. The care manager would be responsible for completing the assessment and setting up an initial care plan(Challis et al.,1990,p.66), which would be reviewed at an informal

case conference. The assessment schedule was based on that used in the social care scheme, with additional medical and mobility assessment, which on occasions identified problems unknown to GPs, including the effects of poor eyesight, diabetes, thyroid deficiency and inadequate fluid intake (Challis et al.,1993,p.193).

*Care planning and care packing:* The inclusion of staff from different disciplines and agencies within the team made it possible to provide a wider range of services, using both health and social services resources(Challis et al., 1993, p.193). The project, with the formulation of a care plan, reflected a clear hierarchy of need, introduced at a variable pace and reflecting principles of flexibility and client choice where possible (Challis et al.,1990,p.67). A social activity group organised around meal times was set up in a sheltered housing unit to provide stimulation, companionship and activity to about ten or twelve elderly people once a week. The team physiotherapist took part in this group and organised a series of simple exercises to music for elderly people, in order to improve mobility and also to monitor their progress(Challis et al.,1993,p.193).

*Monitoring:* Close and regular monitoring of elderly people's well-being, the carer's ability to cope and the adequacy and effectiveness of services were crucially important(Challis et al.,1990,p.70). The usual pattern was one where the care manager, through close contact with the helpers, was able to monitor the situation, and this was supplemented by regular visits to the elderly people, and intervention if there were any difficulties(Challis et al.,1993,p.193).

*Outcome:* The only outcome data available was for a small sample of matched 28 cases. After 12 months 62% of those receiving the care management service remained at home compared with only 21% receiving the usual services (Challis, 1993,p.85). The effect on the prevention of unnecessary admission to residential care was very marked and length of stay in acute hospitals was reduced. The average period of time spent living at home for those receiving the scheme was 39 weeks over one year, compared with 24 weeks in the comparison group(Challis et al.,1993,p.193). As in the social care scheme, it proved possible to offer very vulnerable very elderly people care in their own homes as an alternative to institutional care at no greater cost than the usual services available to them(Challis et al.,1990, p.85).

*The Darlington geriatric care project*

The Darlington scheme, a medium-size town, provided home care to physically frail elderly people who would otherwise require long-stay hospital care. The aim was to extend the care management approach used in Kent and Gateshead into a geriatric multidisciplinary team to reduce overlap between personnel(Challis, 1993,p.85). Also to discharge patients from long-stay geriatric wards(Challis et al.,1988,p.41). The principal concerns in the Darlington project were those of a lack of real choice for, and control by frail elderly people over their care or over the multi-faceted nature of needs spanning the responsibilities of health and social services, overlap and duplication of services, and inflexible patterns of service delivery (Challis et al.,1991,p.236). The project employed by the social services department

consisted of a project manager, three service managers as care managers, and a team of home care assistants. The service managers had to cost the service they provided to clients, working to an average budget of two-thirds of the cost of a long-stay hospital bed(Challis et al.,1993,p.194) and they were also responsible for teams of home care assistants and acted as care manager for putting together and monitoring individual care plans for individual clients (Challis et al.,1988,p.42). The referral, assessment and review of the clients who were to receive the service were undertaken by the geriatric multidisciplinary team, comprising medical staff, hospital and community nursing staff, social workers, paramedical staff and service managers from the project (Challis et al.,1991,p.237). The study compared individuals receiving services from the project with similar group of patients identified in long-stay wards of an adjacent health district, which was seen as providing a reasonably similar style of geriatric service. Their informal carers were also interviewed, focusing on the experience of care and degree of burden, and compared with a third group of carers of elderly people receiving the usual range of health and social services while living in the community (Challis et al., 1993, p.194).

*Case finding:* Case finding was a task of the multidisciplinary team as a whole, and the principal role of the service managers was screening, to ensure that only clients eligible for the project were accepted(Challis et al.,1991,p.237). The target population of the scheme was defined as severely physically handicapped people who were, by and large mentally alert(Challis et al.,1988,p.42). Thirty six males and 65 females were discharged from hospital to the

project and their average age was 80. Most patients had been in hospital for two years or less, 96% of the project group and 90% of the control group(Challis, 1993,p.86). Thirty six projected clients were discharged to live alone; 42 returned to live with a spouse; 16 were discharged to live with other relatives or friends; three were placed with families; and two were placed in a group-living home. The most common cause of impairment was a stroke(one-third of the clients). Most clients had severe mobility and self-care problems, and about two-thirds experienced problems in maintaining continence (Challis et al.,1993,p.195).

*Assessment:* Clients who were to receive the service were assessed by the geriatric multi-disciplinary team, comprising medical staff, hospital and community nursing staff, social workers, paramedical staff and the service managers from the project(Challis,1993,p.86). This service(care) manager coordinated the assessments of the elderly people from the different professionals in the multi-disciplinary team and took responsibility for assessing the family and the potential support network. In about half the cases a home visit was undertaken with elderly people, so that the suitability of elderly people's home environment could be assessed(Challis et al.,1993,p.195).

*Care planning & care packing:* Each care manager was allocated a budget for their caseload of about 20 clients. A large percentage of this budget was allocated to the home care assistant's time, but resources were also spent on paying for additional services from members of the community, and the input of other health and social service resources was also costed(Challis,1993,p.86). Home care assistants were

instructed and used by a variety of different professionals, in an attempt to integrate much of the work of several different hands-on providers into the activities of one single care worker. Thus the functions of a home help, auxiliary nurse or an aid to an occupational group were combined in one person(Challis et al.,1993,p.196).

*Monitoring:* The care managers' prime function was, in consultation with the multi-disciplinary team, to coordinate and regularly review a package of care, linking together all the necessary resources from a range of different providers, formal and informal. As well as the tasks of monitoring, liaison and coordination, this role also required the care manager to give considerable amounts of emotional support and advice to elderly people and their families, complementing the activities of informal cares, and to provide support for the home care assistants and resolve conflicts in the care network(Challis et al.,1993,p.196).

*Outcome:* There was a statistically significant improvement in overall morale and a nearly statistically significant improvement in a measure of satisfaction with their current life situation(Challis et al.,1991b,p.248), and a reduction in depression, compared with the control group. More than half the experimental group were still in their own homes after one year (Challis,1993,p.86). In terms of more practical indicators of quality of care, the Darlington clients experienced greater benefits than the controls, with a significantly reduced need for additional care, and a significant gain in the number of social activities in which they participated, compared to the long-stay patients (Challis et al.,1993,p.197). Project carers carried out

significantly fewer care tasks than day hospital carers, and were significantly less subject to distress associated with the performance of these tasks. Unlike the other three studies there was an apparent cost advantage to the main agencies from the project. Social opportunity cost figures also indicated a significant cost advantage to the project compared to long-stay hospital care(Challis, 1993,p.87).

*Discussion*

The findings from this series of care management schemes in community care of frail elderly people would seem to be remarkably consistent(Challis,1993,p.87). In all three of the projects, according to Challis et al.(1993), needs satisfaction of elderly clients and their carers receiving care management services have improved significantly more than those receiving the traditional services. 'These results were achieved at no greater cost than existing services, indicating improved efficiency in community care'(p.200). Nonetheless, there are several areas of debate concerning the development of care management that are of general application(see international studies on care management in chapter two). Particular concerns include the style of care management, the role or function of both management and manager at clients and systems levels at which care management take place, with implications for targeting, and control over resources.

In terms of models, the Kent social care model - single agency model based on social care - is limited by having direct access to only the social services department. Even if an obvious strength of the single agency model is the

relatively low amount of organisational arrangement and management effort required to establish and maintain such a system, the weakness, as argued in models of care management in chapter two, lies in 'the difficulty of health care staff inputs required for multiple needs clients, particularly health care needs'(Challis et al,1990,p.12). The approach to care management requires the care manager to undertake not only direct work with clients and their carers, but also indirect work in coordinating services. As such, it is closer to clinical care management than some of the more administrative approaches which have focused principally on effective arrangement of services(Challis et al,1990,p.27). Advocacy is a strong feature of care management in the project. The care manager negotiates with representative of the agencies providing services, arguing the client's case and producing reasons for a request to be met. Through using advocacy skills, the care managers begin to exercise authority without having direct control over resources and professionals accept their assessment of their client's need for resources and services(Dant & Gearing, 1990,p.345).

The joint agency model provided by the Gateshead health care scheme appears to have indicated one way to coordinate care more effectively at the level of the individual elderly people(Challis et al.,1991b,p.253).However, interprofessional rivalries and problems associated with securing contributions from outside agencies were identified as significant difficulties in the project(models in chapter two).

The Darlington project brought together the two agencies, health and social services, through care managers located in a geriatric multi-disciplinary team(Challis et al.,1991, p.243). The multi-disciplinary approach helped to break down

barriers between different professional groups (Huntington, 1981; Dant & Gearing,1990,p.154)) and improved communication and collaboration between professionals(ibid). This approach was seen by team members as particularly advantageous since it led to a heightened sensitivity to other problems beyond the single professional remit. This care management role and team working influenced all members and the content of their assessments was seen to have broadened to cover a wider range of needs and problems than any one professional had previously covered(Challis et al.,1990,p.67). Such a model is applicable to a broader context than the immediate one of discharging long-stay patients from hospital, thus offering one means of providing continuing care in the community (Challis et al.,1991,p.243). However, The approach would seem to mean that some agencies have perceived the core tasks of care management as administrative activities that require staff with interpersonal skills(Challis et al.,1993,p.204). With regard to targeting, care targeting is one of the factors associated with the positive results of these studies from the experience of large-scale care management schemes (Kemper,1988;Challis et al.,1993,p.201). What emerges from the UK(PSSRU) projects is that as a strategy for targeting resources in the interests of the public purse, care management is only cost effective under certain limited *conditions*. Expending access to community care through care management in the UK, as Dant & Gearing(1990) argue, is likely to make 'community care more expensive than institutional care unless it is very finely targeted and exploits free informal carers'(p.344). It is unwise to generalise these finding to the care of less frail elderly people where the opportunity for substitution of

institutional by community provision is smaller.

Some aspects of the practicalities of devolved budgets and managing resources at or near the individual clients were designed to permit more flexibility(see models in chapter two). However, there is a danger in that two important aspects of the care management role are given diminishing importance. One is liaison and communications between professionals and providers about meeting needs and co-ordinating services. The other is the personal support which is an important service in itself and provides a context in which the elderly people at risk can assert their own needs rather than those someone has assessed them as having(Dant & Gearing,1990,p.375).

In focusing on cost effectiveness, all of the PSSRU projects showed a degree of improved quality of services for elderly people and their carers compared with existing normal care services. Only one, Darlington, implemented a consolidated community care service for elderly people with a multi-disciplinary team, of the four projects which demonstrated a certain(significant) degree of cost-effectiveness.

The projects have been subject to rigorous quantitative evaluation in terms of the quality and effects of their service delivery processes and cost-involvement. The research used a quasi-experimental design with comparisons being made between two groups of matched pairs. It is tricky to ensure that the groups are matched on sufficient criteria for them to be compared for a study which must involve such a very complex mixture of variables. Even if matching is successful in establishing a basis for comparison, it is still not clear what brought about the differences between the groups. It could have been the use of care management techniques, or the

use of relatively low-paid local helpers, or having a specialised and specially chosen social work team, or the Hawthorne effect(Dant & Gearing, 1990, p.347).

All projects indicate that it is possible, with care management and flexible use of resources, both to provide community care of a higher quality and to reduce levels of stress on carers of frail elderly people at no greater cost than the usual pattern of provision for those people. However, it would be unwise to overgeneralise these findings to cover the care of frail elderly people in a very different community such as Korea. Nonetheless, it is clear that all the projects have demonstrated viable models which could be feasible for the development of a care management approach in community care in Korea. Further discussion on the feasibility and strategies to implement the three models for Korea are given in chapter five.

## SOME IMPLICATION OF UK CARE MANAGEMENT IN THE TRANSITION TO COMMUNITY CARE FROM FAMILY CARE FOR ELDERLY PEOPLE IN KOREA

The UK experience confirms that care management cannot work towards an effective coordination of services in community care on the basis of need assessment to benefit clients without a necessary pre-requisite, ie. a mixed economy of care and the purchasers/providers separation. It is consistent with a lesson from international studies(see chapter two).

Claims for the feasibility or appropriateness of care management in Korea, based on experience in the UK, must be treated with caution. This is because, as mentioned earlier,

the UK social welfare system, especially its health and social care delivery system, is structurally different from that of Korea(see chapters four and five). For example, in the UK a care manager can function as a services coordinator, but this may not yet be possible in rural areas of Korea. Further, public attitudes to welfare(the typical ideology) in Korea are different from those of the UK.

## Implication of the neoliberalism and globalization for welfare provisions in the UK and Korea.

Internationally the welfare consensus started to dissolve from the mid-1970s, caused by the slow down of the world economy, the eventual collapse of the Soviet block, and involved issues ranging from the waning of wartime solidarity to the tax-revolt of the rich(Ferge,1997,p.21) without any clear indication of what it was going to be replaced with(Hettne, 1990, p.17). These changes demanded a new image of society and an associated social policy (Ferge,1997,p.21). Some social policy makers look for the solution in a revival of community while others want to leave all decisions to the market with as little public intervention as possible (Hettne,1990,p.17), such alternatives termed by different authors as neo-liberal, post-Fordist, post-industrial or post-modern(Taylor-Gooby, 1995, Therborn,1995; Ferge,1997, p.21). As far as the philosophical basis of their thinking is concerned, they have highly valued the individual's freedom of decision-making and individual responsibility. On the one hand, as economies become increasingly globalized, the structure of the market is changing: supranational economic agencies tend to dominate the formal national market sectors (Ferge,1997,pp.22-23). Cerny argues that the key to

understanding globalisation is the effect on the sector of public goods including redistributive goods such as health and welfare services - all are becoming steadily more difficult to provide and control (Cerny,1995; Rhodes, 1996,p.308). Even attempts to explore the relationship between the national and the global in the welfare arena have been partial, incompletely theorized, empirically limited and fragmented by discipline(Rhodes,1996,p.305).

Another key concept in this debate is 'pluralism'. The pervasive new ideology exalts freedom: the importance of the freedom of choice of individuals, the rejection of monopolistic or uniform solutions, in short, pluralism in all fields. Yet there are factors which impose hardening constraints on the scope for autonomous choice and pluralistic solutions. One of these is an increasingly pervasive and monolithic ideology concerning the unquestionable superiority of a market-driven world (Ferge,1997,p.24).

With the alteration of values and institutions, the field available to the actors in, and modes of operation of social policy is also changing. The state is curtailing its role with regard to financing and delivering services. The first function is in part not replaceable by the management of pluralism. Financing may remain a state function at least so long as quasi-markets are accepted as a solution. The other aspect of service resources as well as service delivery is a shift onto family, voluntary and market sectors(Ferge, 1997,p.28). The mixed economy of welfare may become much more important for service delivery under neoliberalism and globalization.

Since the early 1970s, the UK has been consistently falling

behind its main economic rivals, such as USA and Japan, in trade and production. Different commentators have tried to assess what had happened and to make proposals about what ought to happen. As argued in the previous chapter, the New Right were taken at their face value assumed that the state was being restructured on the basis of neoliberalism (Loney,1987, p.141). Consequently, in social policy debates the trend was to pose the merit of the market(privatisation) and a need to reduce the state role. The government encouraged and supported new initiatives, ones which involved substantially more participation and a greater reliance on informal sector contributions and the market. The new patterns were presented as due to budgetary and resource constraints and the cost-effectiveness imperative (Walker, 1989,p.207), as part of policies of the mixed economy of welfare(Johnson, 1987,p.56).

According to Mishra(1990), two closely linked themes within the mixed economy of welfare literature are decentralisation and participation. Decentralisation is seen by its proponents as valuable in reducing the power of the state and as a prerequisite for successful participation(p.110). The emphasis on a mixed economy of welfare that aims towards decentralisation and participation fits in well with policies of community care(Johnson,1987,p.58). However, there were worries about greater use of the mixed economy of care in community care. The Audit Commission Report(1986) argued that 'this meant the inadequate management of resources, especially missing out a wider range of more flexible and more cost-effective use of resources in community care' (p.27). In response to these arguments, the Griffiths report(1988) recommended the use of care management in

community care to cope with these problems(see the first section of this chapter).

Fundamental to welfare provision in Korea is the fact that it has been taking place during a rapid development of the economy and the process of speedy transformation of social change since the 1960s(see chapter one). Korea now matches some European countries in economic development, but its social security systems remain much less comprehensive (Esping-Andersen, 1996,p.viiii). Social policy has concentrated on creating a safety net and on temporary selective measures aiming at protection of the standard of living of the weakest groups in society(Choi,1996,p.18). As Ksiezopolski(1993) argued, measures directed at the transformation of social policy to adapt it to the new socio-economic environment should be equally important (p.180). However, one effect of globalization is that it 'cruelly punishes wasteful governments and uncompetitive economies' (Esping-Andersen,1996,p.2). It is therefore to be recognised that the functional aspect of expenditure for welfare provisions should be consistent with the needs of the larger society, particularly economic productivity (Stoesz ,1988, p.58). This is consistent with recent developments in social care provisions in Korea(see the macro level of findings in chapter six). Applying a functional concept to clients groups that are not as productive economically, such as elderly people, means such groups may have to strive harder to retain their worth for welfare in an era of competitiveness(Stoesz ,1988,59).

There is a perceived trade-off between social security and economic growth, between equality and efficiency, with a

reluctance to building costly welfare provisions(Esping-Andersen,1996,pp.2-3). The Korean government has encouraged the development of the private and voluntary sectors to construct a mixed economy of welfare as an infrastructure in order to moderate welfare demands(see chapter one). As a consequence, social care provision is being transformed into a mixed economy of care from a residual care policy that operated within a family framework. Policy makers in Korea emphasised the residual approach for vulnerable groups as a basic welfare policy (Choi,1996,p.18). Individual welfare has been regarded as a private concern - primarily a family responsibility - with state intervention justified principally on the basis of basic needs beyond the capabilities of any individual or family(Walker & Wong,1996, p.83). According to Kemeny(1995), residual welfare systems tend to be associated with countries possessing neoliberal regimes, based on liberal philosophies of minimal state intervention(p.89). Even regime theory in itself may be insufficient for a full explanation of the contemporary development of welfare provision in Korea. Korea should be regarded as near to the model of neoliberal welfare state regimes from a review of the western construction of welfare state regimes.

As argued in the introduction, international adaptation of welfare provisions is difficult for a variety of reasons, including political and socio-economic differences across countries. Nevertheless, Korean welfare policy the mixture of welfare under neoliberalism is in the same direction as that in the UK, although Korea has pursued toward these policies from a very different starting point and levels than has been the case in the UK. Allowing for context, it

can be argued that certain welfare provisions developed in the UK could be adapted for social welfare developments in Korea.

## Some implications of the UK care management for the development of care management in community care in Korea

Some Korean writers expect that care management is a flexible approach, suitable to achieve some needed effects in community care for elderly people, overriding any alternatives mechanism in Korea. Yet the implementation of a care management approach can not act as a substitute for the services themselves. The process of implementation of care management may be characterized as producing some more complicated issues because the structuring will take place within an existing service delivery structure. No literature discusses how to introduce care management into existing systems, while the models which have been discussed differ widely(Davies,1992,p.120). Furthermore, there is a hunger for information and evidence about care management in rural settings, defined in the UK by a population of around 25,000 and in an agricultural area. Thus it would be valuable to discuss even limited information on, for example, care management in rural areas.

### *Style of care management*

In relation to style of care management, there is a debate between the administrative and clinical care management approaches(Harris & Bachrach,1988; Challis et al.,1993,

p.201). According to Dant & Gearing(1990), much depends on the plurality of services and the complexity of need of the clients(p.345). The plurality of social care resources for the care of elderly people in Korea can be considered. Community care programs involve governmental agencies, private providers, voluntary centres, and families. However, they are subject to a separate range and scope of activity. Services for elderly people have to be continually adapted to changes in their pattern of need. Combining health and social care inputs is particularly important for multiple-needs elderly people, to judge from the UK experience. Therefore, a development of care management which is supported by joint agency working may especially be appropriate in Korea(see chapters four and five). Social workers or nurses as care managers may perform their practical work with the use of interpersonal skills for elderly people and their carers, including counselling, and emotional support, as well as indirect work in services coordination and linkage within the joint agency model(see care management models in chapter two and care managers'roles in this chapter). Such a combination approach ,according to Challis(1993), might be deemed integral to a clinical model of care management. This model is a valid and useful one to counter the risk of bureaucratization and insensitivity (p.88).

In situations with a wide geographical spread or with placement diversity, care planning techniques varied in response to local operational and management conditions (Knapp et al.,1992,p.220). Care managers working in a poor service areas - often rural areas - may have comparatively few choices in performing these tasks in Korea. Delivery

systems have the primary task of enhancing clients access to a limited number of services that are available. In such settings, care management may also be engaged in the twin functions of service development and services linkage or coordination in Korea(see chapter five). However, unlike in rural areas, care management is focused on coordination services in the urban areas in Korea.

*Assessment instruments and staff roles*

One of the major issues that care management faces would be instituting a new system of resource management that was in some way linked to assessment instruments. This provides guidance to the care manager for meeting client's needs, but also fits with its own existing system, such as the managerial and professional system in the UK(Bannerman & Robertson,1996,p.81). The development of assessment instruments may involve some organisational, administrative, and professional tension related to the change of social workers' roles, tasks and relationships with other professionals, especially nurses, with the introduction of care management into Korea.

The roles, tasks and professional development of staff working as care managers also creates questions about patterns of care management in Korea. The nature of care management tends to focus on the need for coordination of services, reflecting the importance of dealing with fragmented care systems and multiful care providers and providing need-based services(Challis,1993, p.88). Therefore, care managers have been viewed as engaging in direct(eg. counsellor) and indirect practice(eg. coordinator), or both.

In addition to these, as Wolk et al.(1994) argue, care managers also engage in managerial roles. These roles are: interpersonal, including acting as figurehead, a leader, and liaison; informal, including monitor, disseminator, and spokesperson; and decision making, including entrepreneur, disturbance handler, resource allocator, and negotiator (p.152).

*Training and staff development*

A review of the UK experience identifies issues of training, to achieve integration of services and control over adequate resources, to coordinate care for elderly people. Classifying the training needs of care managers results in three major categories. Firstly, understanding the client's circumstances (eg. knowledge of their health and disability limitations); secondly, understanding the environment at the systems level(eg. support mechanisms); and thirdly, mastering techniques for the process of care management(eg. functions of assessment). There may not be enough experienced professionals who have had those kinds of practice or experts designing and delivering relevant training in Korea. Some departments, notably social work, nursing, or education studies in universities, must extend education in these subjects, relating to the categories mentioned above(see strategies in chapter five). Professionals acting as care managers will have to acquire skills and training relevant to care management for successful implementation.

# CHAPTER IV

# COMMUNITY CARE FOR ELDERLY PEOPLE IN KOREA

As with many social science terminologies, the meaning of 'community care' is abstract and ambiguous. The term is value laden in the sense that people, consciously or unconsciously, inject their own values(Chan & Tsui,1997, p.177) into their definition of community care. In addition, community care is used to describe ends as well as means in the West. The expansion of the definition has given us a broader understanding of the subject, but also obscures its boundary. One of the confusions is the different use of the term 'community care' in Korea. The term community care is equally called 'home care' or 'home-based care', influenced by the USA and Japan. A few articles published in Korea use the term community care instead of using home care/home-based care, as for instance in Oh,JS.(1996), 'comparative study of the administrative structure of community care between Korean and England'. Today, the term community care in Korea typically refers to community-based services that provide an alternative to only family care at home.

Korea has conducted no systematic studies in community care. This chapter discuss exploratory studies into (a) the development of community care policy for elderly people in Korea, (b) community care practice for elderly people in Korea, and (c) the needs of elderly people and carers in community care in Korea.

## THE DEVELOPMENT FRAMEWORK OF COMMUNITY CARE FOR ELDERLY PEOPLE

Definitions, theories, and classifications of community care have been formulated mainly for western societies, especially the UK. However, the notion of community care is not unique to the West. As Mohan(1988) argued, even the perception of the meaning of community care sharply differentiates its content, 'the philosophy and practice of community care is deeply embedded in the values of Occidental and Oriental cultures'(Chan & Tsui,1997,p.178). Community care has a long history in Korea and the notions can be traced back to the Lee Dynasty(1392-1910). During that era there were well-formulated notions regarding care in(by) a community derived from Confucian thought. The care system in a community was one of the minimal and residual institutions and traditional care in(by) the community, which means that care was provided by ordinary members of the community: family, friends, neighbours, and volunteers without the state services. The modern notions of community care in Korea have exploded during the social change accompanying the process of industrialization(see chapter one). The main purpose of this subsection is to identify traditional roots of community care for elderly people in Korea from the Lee Dynasty to the end of 1970s.

### The traditional roots of community care for elderly people

*Before the Korean War(1950)*

The traditional Korean values and beliefs have mainly been

a mixture of several religions - centered on Confucianism and Buddhism(Cherry,1993,p.85). The main foundation of care thinking in(by) a community in Korean culture is Confucian philosophy. In Confucian thinking about care in(by) a community, there are several points to note in Korea. Firstly, an individual is involved in well-structured networks of human relationships in Korean society. Everyone is assigned duties and responsibilities within the networks of the society. Help and concern come from the members themselves because they are part of the intricate social networks. In terms of caring for other people, the guiding principle of duty/responsibility is based on the consensus of the members of a network. Care obligation in Confucianism is care by the network community, which would come stress in a western type of community care.

Secondly, a major social bond is the kinship network in Confucian thought. The family is the center of caring networks. But, the individual is engaged in some relationships at many different levels(Chan & Tsui, 1997, p.179). In Korean tradition, the responsibility of the higher hierarchy is to take care of lower members in a network - son to a father, or a subject to a ruler, the younger to the elder(Cherry,1993,p.87). Caring services stem primarily from the mixture of obligations resulting from relationship networks, resulting in pluralistic, informal services in a community. Thirdly, relationships within networks lie at the root of the trust of the members. The most treasured norms are harmony and interdependence. 'Care and concerns are given on a voluntary basis. Being helped is not a right, but helping another is a responsibility'(Chan & Tusi,1997,p.180). Another source of the voluntary sense is Buddhism in Korea.

Charity behavior expecting nothing in return is emphasized by Buddhism. Buddhist monasteries were the major sources of distinctive cultural activity in Korea in the past and formed the backbone of the voluntary sector in Korea. This may fit in with some notions of community care in western societies, in which there is an emphasis on informal and voluntary participation.

Although the Confucian and Buddhist conceptions of care in(by) a community seem not exactly to go with the western notions of community care, there have been a number of similar concrete measures proposed for community care, such as emphasizing network community, pluralistic caring services, and informal and voluntary participation.

From Buddhist and Confucian philosophy in Korean culture and history mentioned above comes a study of the nature of traditional care in(by) community networks. These community networks were the *Hyangyak*, which were organized by all members of a community to cope with some difficulties; and the *Kye*, whose members were composed by their specific interest(eg.carers group/self-help groups). The *Hyangyak* was a village code to set up a system of mutual support and is the most outstanding example of a community network in a community in Korea. The spirit of the *Hyangyak* was embodied in four objectives: mutual encouragement of morality, mutual supervision of misconduct, mutual decorum in social relationships, and mutual help in time of disaster or hardship(Lee, 1984, p.207: Lee, 1997b,p.123). The networks were nationwide in Korea until around the 1950s. At the end of the 1940s there were several thousand in the whole country.

The *Kye* is also one example of a reciprocal community

network. A *Kye* is a voluntary, non-legal association of community members for a single specific purpose, such as collection of money to finance mutual social welfare and economic activities. Through the networks, community members help each other in problem-solving. A *Kye* form of community network is still popular with thousands in existence today. The *Kye* networks have recently been organized by reason of emotional attachment much more than for economic needs(You,1986,p.49). In the past they catered more to economic needs.

The essential functions of the traditional community networks, the *Hyangyak* and the *Kye*, were to provide a community member with mutual help in day-to-day living. These networks were created by the initiative of community members rather than by officials. The traditional care in(by) the community in Korea was a system of underdevelopment in the formal sector with heavy reliance on the informal and voluntary sectors. It may be summarized as individual responsibility for the collective good.

*1960s-1970s*

Through land reform(1947), the Korean War(1950-1953), and in the process of industrialization since early 1960s, the traditional community and community networks were broken down(see chapter one). The informal traditional care in community has been gradually replaced by more formally expanded methods such as official intervention by the state and reorganized voluntary organization. The basic infrastructure of care in(by) the community started from collectivization of the means of production through the

*Saemaul* movement(new community movement) launched in 1972. The movement was centered on self-help and cooperation (mutual support) networks in a community. The movement showed that 'not only I but my neighbors, community members and all our people live well'(MHARK,1983,p.10).

The organization of care was concentrated within the formal networks in a community. The community was responsible for health care, social security and housing. The notion of family care and self-help were still fundamental principles of care in(by) a community in Korea, especially in rural areas. When individuals and family cannot solve a problem of care for elderly people, the collective concern steps in. Community care in the form of ecologically based networks has shaped by these new forms of collectivity. These systems have distinctive historical features and tend to act as a central point to care in(by) a community in Korea. Their spirit exists and functions widely in contemporary Korea. They necessarily represent community networks, which are most targeted by the recent debates on community care in relation to the imminent issue of the ageing society.

## The development of community care for elderly people

Payne(1995) argued that 'any understanding of the development context of community care must be partly historical'. The pattern of a new service always derives from what has gone before, and the thinking which creates an innovation is a reaction against aspects of past provision(p.31). The purpose of this subsection is to discuss the main developments of community care for elderly people since the early 1980s and to look forward to the implications of the continuation of

present trends in Korea. The analysis is based on a Welfare Act, and not only because this Law performs a role as a means for planning by society.

The Elderly Welfare Act(EWA) is an incorporation of the ideals, values, social roles and functions of welfare services for elderly people, but it is also significant because the absence of clear policy or of detailed reports published by the government has been demonstrated in the development of community care in Korea.

Three phases are identified in the historical development of community care for elderly people(see table 4-1).

Table 4-1: The development of community care for elderly people in Korea

| Period | Phase | Comments |
|---|---|---|
| * 1981-1986 | The recognition | Social needs as social rights |
| * 1987-1991 | The commitment | Increasingly committed developments of services responding to social need |
| * 1992-Present | The expansion | Policy implementation in response to social needs |

Firstly, in the recognition phase, the Elderly Welfare Act of 1981 made responses to social needs as elderly people's social right. Community care reflects the pressure for change to existing policies that comes from below, from elderly people themselves and their interest representations (Scharf & Wenger,1995, p.217). But the family care tradition which underpinned the political ideology inherent in a budget reluctant allocation of budget, is also involved in providing care of elderly people(see chapter 1). The second phase has increasingly emphasized the development of the state sector in order to respond to social need. In third phase reactions

to social need led to a growing emphasis on the idea of a mixed economy of care as the basis for a response to elderly people's need, and as a central concept from the 1990s onwards.

*The recognition phase(1981-1986)*

As discussed earlier, Korea has undergone a great social change with her economic, political, and social welfare structures in the process of industrialization and modernization since the early 1960s. Such changes have generated stimulation for transformation from traditional care in the community(family-centred care) to state sponsored community care in a very short time(see chapter one).
Since the early 1980s some new social needs for a better quality for life of elderly people have been raised due to the changes in socio-economic conditions. The alienated elderly groups, hidden in the shadow of economic development, have increased the need for welfare as a social right. Elderly people have begun to take direct action by themselves, or in coalition with other interest groups, in seeking to achieve the right to be treated with dignity and the right to have welfare needs met according to the Constitution(Sung,1995,p.129). At the same time, the military government suffered from a weakness of political legitimacy, making it essential for the government to take measures to build popular support(Lee,1997b,p.206).
These factors forced the government to enact the Elderly Welfare Act of 1981(EWA). The EWA was part of a welfare measure provided for elderly people for the first time in Korea. It did not contain any clear policy objectives or

targets for community care, but, the EWA was to play a key role in providing a concrete embodiment of the idea of legal rights of elderly people in Korea, enabling elderly people to secure the social rights which related to their actual life. The EWA was based on the concept that the state shall make provision for the welfare of elderly people who suffer from social and economic difficulties. In this way the EWA created an important environmental context for community care for the elderly.

The next significant event was the respect-for-aged charter(MHSARK) in 1982. The charter(article 1) emphasized partnership for the care of elderly people between family, community, and the state:

"Elderly people have to be cared for in their home by offspring to keep traditional morale. The community and the state have to support them"(translated into English by the present writer).

The main focus was that elderly people should receive services which could be delivered in their own home if needed and increasingly the key support was located not with the family but with the community and state. Care for elderly people was seen by the Charter as a matter where the concerns and responsibility should be shared by the whole community.

*The commitment phase(1987-1991)*

The symbolic event which initiated formal community care for elderly people was the implementation of a voluntary home help service in Korea in 1987. This was the result of the UK Help Age International project which provided funds and technical aid in order to set up home help services for elderly people, by the Korean association of community care

for the aged in 1986 (Choi, 1997,p.87). The service was organized by the association . The subsequent development of home help services was in 1989 at two the general welfare centers for elderly people supported by Seoul local government(Choi,1997,p.381). A home help service was needed simply because of the awareness of a growing number of elderly people who could not manage their daily life in their home without help from outside. The development of a home help service in Korea took place in a context where it was assumed that the best way of providing services for frail elderly people was through employment of voluntary home helpers (Kho,1997,p.18). Attempts were made to provide home help services through the *Bokji Kwan*(the welfare centre), a locally managed system of social service within the 1989 Elderly Welfare Act. The Elderly Welfare Act(MJRK) clearly stated that;

"For the unfortunate aged who have physical or mental disability, but are not admitted to and protected in an old-age welfare facility...the welfare executing authorities shall appoint the home help service personnel who give such aged home services (Article 11(2).

In the meantime family obligation acting as a moral code tended to be underlined as the characteristic form in the care of elderly people in Korea. However, social change increasingly required using social services from the state, or formal provisions, rather than from the family, as mechanisms to provide care for elderly people(see chapter one). That is why it was stipulated by the Act(1989) that:

"The state and citizens shall make efforts to maintain and develop a sound family system on the basis of public morals respecting the aged...The state and local governments shall be responsible for promoting the welfare of the aged...upon adopting policies concerning the welfare of the aged"(Article 3 & 4).

The principal strategy pursued by the government was residualisation in the provision of services for elderly people, yet the main trust of policy has been towards increasing the role of local government as service provider

*The expansion(1992-present)*

Approaching the 1990s, community care as a formal policy has been widely accepted by policy-makers and many professional ideologies in Korea. Writers such as Kim,BS. (1992) and Oh, JS.(1995) introduced the trend of home care/community care from the western countries such as the UK, Japan, and USA into Korean society. Policy-makers have been seeking cheaper alternatives to the cost of running and maintaining welfare provisions for elderly people(see chapter one). Therefore, community care has been emphasized as the basic direction of social policy for elderly people (Lee, 1997a,p.118). In 1992 the 7th Five-Year Socio-economic Development Plan(1992-1996), according to Kim(1997a), was a creature of its time:

"Elderly people have to be provided with services to be cared for within family system and the community care service has to be expanded in order to use a variety of community services"(p.156).

No clear guidance was provided on the objectives which services and policies should pursue. The plan emphasized that a variety of community services should be involved in providing support and care for elderly people. All these changes set the stage for the events leading to the community care embodied in the EWA of 1993. The EWA defined the term 'community care' as:

"Community care for elderly people is to provide necessary care and support in their own home in order to promote the welfare of the aged who have a physical or mental disability (Article 11). The main services in practice in community care are home help .., day care.., and short-term care .."(Article 20(2),translated from the Korean version by the present writer).

There is an attempt to define and quantify the clients for community care, to set policy goals and then relate these to the allocation of services. However, there is no statement about who should or would provide what care for elderly people. In terms of providers of services, the Act stressed the development of a mixed economy of care, to provide services according to clients' needs. Great emphasis on non-state sectors, especially private resources, was proposed (Kho,1997,p.18).

"Any person who operates a business related to the daily life of the aged, shall make efforts to promote the welfare of the aged in operating his business"(Article 4). The welfare executing authorities may give proper assistance to those who operate the home service projects, connection projects and other projects for the purpose of welfare improvement of the aged at home"(Article 11(2)).

As a matter of philosophy, the government prefers non-state options, especially from private sector, for the provision of services in community care(Kho,1997,p.18). In parallel with these changes, launching local autonomous government in 1995 was to encourage local authorities to act as the main bodies for community care for elderly people(see chapter five). The Ministry of Health and Welfare(1995) also argued that community care is the responsibility of local authorities, which are charged with setting up welfare facilities, developing services, assessing the needs of clients, and putting together services from private and voluntary organizations (p.11). In addition to this, *the Boken Bokji Samuso project*(the Health and Welfare Centre

Project,HWCP) in 1995 offered a transplantation of political will and policy on community care into practice(see the following section).

To sum up, a current form of community care in Korea since the early 1980s has demonstrated a certain diffusion of western ideology into Korea. That is, community care has been developed both to provide care and to deal with growing social needs/problems relevant to frail elderly people. Although the community care system is similar to that of the West in terms of emphasising traditional values such as family, self-help, and interdependent, informal care, they clearly differ in the aims of development of community care policy. Korean community care is an alternative to family care or traditional cultural practice. However, the western form is mainly an alternative to institutional care.

Table 4-2: The landmarks of community care for elderly people in Korea

| | |
|---|---|
| 1981 | The Elderly Welfare Act |
| 1982 | The respect-for-aged Charter |
| 1986 | The UK Help Age International's support for home help service for elderly people |
| 1987 | Home help service project(public level) |
| 1989 | Home help service project(Seoul local government) |
| 1989 | The Elderly Welfare Act(amended) |
| 1992 | The 7th, five-year socioeconomic development plan |
| 1993 | The Elderly Welfare Act(amended) |
| 1995 | The Health and Welfare Centre project |

## COMMUNITY CARE FOR ELDERLY PEOPLE IN PRACTICE

Many vulnerable people have been left at greater risk without an adequate access to social and health services. It is one of the national and local concerns in Korea. In this study,

'vulnerable people' are defined as childless elderly people; people with mental/physical disabilities; and parentless children under the government-mandated poverty line. Community care has become a primary strategy in order to alleviate problems of these vulnerable people and has been a popular tool in Korea since the 1990s.

This section investigates some major issues in community care incurred in a recent years and examines the delivery system of community care, tasks of social workers, and resources available in community care. For the empirical research, samples are selected as two *(Kwanak-ku*(urban) and *Hongchen-kun*(rural)) of the five areas participating in the Health and Welfare Center Project(HWCP). Rural and urban areas were used for comparative purposes(see research methodology for how typical the two areas are of other urban and rural areas in Korea).

## The service delivery system of community care

At present, community care in Korea is delivered through a dual system. One is health care administered by the *Bokunso*(Health Centre), the other is social care provided by social workers in *Myun/Up*(a district office). This is now a nationwide system of community care.

On the other hand,the implementation of new service delivery system of community care has become intimately bound up with joint collaboration between social and health services in *the Boken Bokji Samuso project*(the HWCP). According to this project, local authorities should play a major role in planning and organising community services by an employed social worker. The role of *Boken Bokji Samuso*(the Health and

Welfare Centre,HWC) is, therefore, an enabling one, helping elderly people to care forthemselves and providing a framework of support. The project tends to set out the role of the social service provisions in relation to the health services, and the relationship(co-ordination) with the state sector. There have rapidly expanded in the field of community care, and involve independent sectors(informal sectors and private), which have been the major providers of most types of community care(social care). It has made a new pattern of relationship between state and public sectors possible.
This subsection provides a systemic overview of some characteristics of the service delivery system in the Health and Welfare Center Project in Korea. Firstly, the background of the Health and Welfare Center, including the goals and objectives, is described, followed by the structure, financing, manpower and tasks of the Center.

*Background of the Health and Welfare Center Project*

In Korea, as argued in chapter one, the problems of vulnerable people are closely interrelated with economic growth, technological advances, and changes in moral, social, and religious value systems. Many vulnerable people in Korea still exist in conditions where health/social care and support are minimal. Consideration of possible improvement in quality of life is meaningless to them (Yean,1981,p5). However, needs of vulnerable people have been identified and services have been provided and are being planned to meet their needs. One of these plans is the Health and Welfare Center Project(HWCP). The basic goal of the HWCP is to develop a service delivery system for providing better care

and support to vulnerable people in a community. The primary objectives of the new service delivery system are: (a) to provide integrated services between health and social care ; (b) to develop an extended range and variety of support services; (c) to use resources flexibly and effectively; (d) to improve the planning and coordination of services(Lee et al.,1995, pp.15-16).

As mentioned earlier, the HWCP, launched in 1995, is to translate the political will and policy into community care in practice. In January 1994, the Committee for Social Policy proposed to set up the Health and Welfare Centers at a county level. The impetus for the development of the project, aimed at community care for vulnerable people, seems to have come in part from social, moral, and fiscal imperatives. The social imperative is related to the social change that the functions of *Bokenso*(Health Center) are required to provide for extended services from health services such as family planning and preventing contagious diseases to community care services, including a community psychiatric service and home visiting nurses. The health care system as it currently operates does not always meet the needs of vulnerable people(Lee et al.,1995,p.41). The moral imperative is related to the notion of providing services in the least restrictive setting in order to normalize the lives of vulnerable people as much as possible(Bennett et al.,1984, p.xii). In relation to the fiscal factor, it is recognised that there has to be adequate funding to set up a new service delivery system for community care. Therefore, alternatively, there may be a need for reorganisation within the current system. Initially it must be handled at the periphery, concentrating on urgent issues (Kim,1997b, interview).

In the autumn of 1994, in response to the proposal, the government started to develop the blueprint for the project. To carry out the program, the Ministry of Health and Welfare of the central government selected five areas including two urban areas(*Kwanak-ku* in Seoul, *Talse-ku* in Taegu), one semi-urban area(*Ansan-si* in Kyungki province), and two rural areas(*Hongchen-kun* in Kwanwon and *Wanju-kun* in Chenbook provinces). The project was launched in July 1995.

*The structure of the Health and Welfare Centre*

Important components of a community care system are its administrative arrangements and capacity to deliver the services, taking account of their service users(Koff, 1982,p.64). The structure of the Health and Welfare Centre is designed to test a service delivery structure to provide a wide spectrum of joint collaboration between health and social care in community care and to bring the availability of comprehensive community care to clients who require care/support through the mixed economy of care structure(Lee et al.,1995,p.46).

**Service delivery system of the Health and Welfare Centre(HWC)**

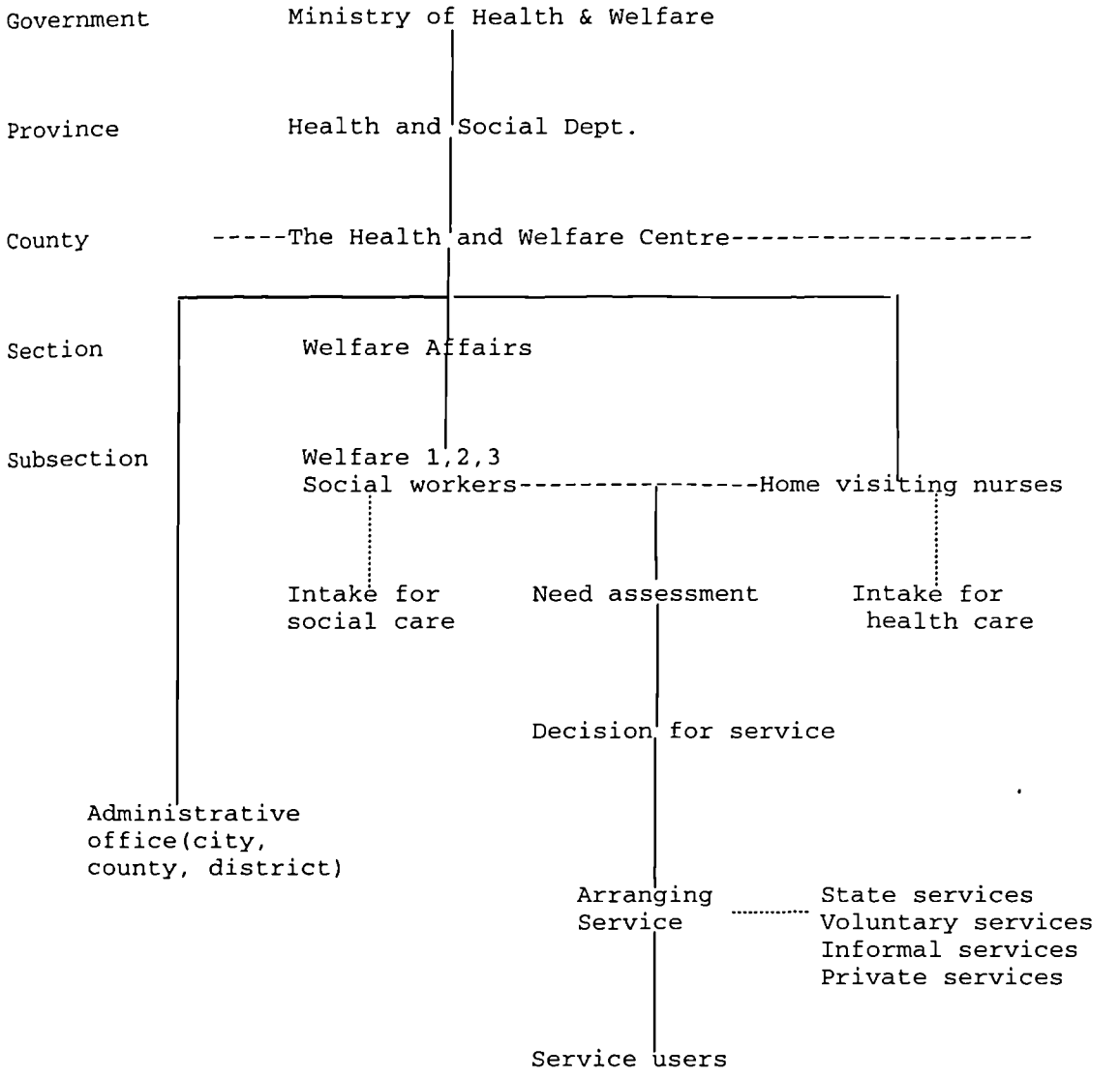
Community care is carried out by the Health and Welfare Centre through joint collaboration between health and social care at the county level. Integration is designed to increase efficiency in community care and avoid unnecessary overlaps. Figure 4-1 summarizes the flow chart dealing with components of organisations and the service delivery system. There are three layers to the working system: Central government

(*Jengbu*), provincial (*Do*), and county(Gun)/(*Gu*)) levels. Responsibility for the planning and implementation of a community care project rests with the local government at county level.

Four kinds of organisations are involved in the main structure of community care - (a) the Health and Welfare Centre, (b) administrative offices(city, county, district), (c)service sectors(the state, the voluntary, informal, and private), and (d) service users. The HWC cooperates with administrative offices(city, county, and district) with administration matters and contracts with service sectors to provide services for elderly people.

In terms of service delivery, there are two main bodies to provide community care services in the HWC. One is concerned in the subsections, Welfare 1, 2, 3 for social care by social workers. The lead roles of the subsections are intake, need assessment, decision for services, and arranging services for the clients. The second other body is the home visiting nursing team to provide health care. Health care includes all services providing for personal and family health care, both preventive and therapeutic. In addition to these, there are the administration offices supporting social workers and home visiting nurses. Rural and semi-urban structures of the service delivery system in the project are similar to that of the urban structures described in this study.

Figure 4-1: Service delivery system of the Health & Welfare Centre(Kwanak-ku,urban)




Source: MHWRK(1995), Tasks manual of the Health and Welfare Centre, Seoul, MHWRK, p.12.

**The finances, manpower, and tasks of the HWC**

As seen in Figure 4-1, community care must be connected to the central government structure. About 30-50% of the funds(50% in rural & 30% in urban) for services is provided by the central government from general revenues. The HWC receives its other budget from the local government to

provide community care. The level of the budget depends on the number of service users in the catchment area and on the number of staff(MHWRK, 1995, p.80).

The HWC is staffed with social workers, doctors, usually a physician, several nurses, technical, and administrative personnel supporting staff to carry out the project for the whole *Kun/Ku*(county). In the HWC there are at least two levels of nurses, a first expert level(3-4 year education) and a second expert level(6-12 months training) in a home visiting nursing team. This compares with the length of education of a qualified social worker which is four years in a university.

In *Kwanak-ku*(urban), there are 15 first expert level nurses. In addition, there are 22 qualified social workers. However, in *Hongchen-kun*(rural), there are 11 qualified social workers, 5 first level nurses, and 32 second level nurses(see research area in introduction).

The HWC consists of five segment sections(health administration, health extension, medicine, local health, and welfare affairs). Under welfare affairs there are four subsections(welfare 1, 2 and 3, and home visiting nurse team(s)) for community care.

The following subjects must be handled by each subsection(see table 4-3): Welfare 1(e.g.counselling, advertisement); Welfare 2(e.g.low-income household, youth); Welfare 3(e.g.mental and physical disabilities, elderly people); and home visiting nurse team. Social workers are responsible for office-based tasks and field-based tasks.

Table 4-3: Structure, tasks of the HWC

| Section | Subsection | Tasks |
|---|---|---|
| Welfare Affairs | Welfare 1 | * Counselling<br>* Advertisement<br>* Computing & statistics<br>* Benefits<br>* Resources development<br>* Service linkage<br>* Issue of documents<br>* Administration |
| | Welfare 2 | * Low-income household<br>* Children & Youth<br>* Family<br>* Community |
| | Welfare 3 | * Mental & physical disabilities<br>* Elderly people<br>* Single mother/father household<br>* TB patients<br>* Health & medical |
| | Home visiting nursing team | |

Source:MHWRK(1995), Tasks manual of the Health and Welfare Centre, Seoul, MHWARK, pp.21-23.

*Discussion: Assessment of service delivery system*

The joint collaborative service delivery in the HWC is assessed as a means of potentially improving services by providing more co-ordinated arrangements to care, thus making community care services more accessible and acceptable to service users. Furthermore, this arrangement can improve services by facilitating the appropriate use of health and social care services. This approach can contribute to effective service delivery in community care.

To work effectively in this approach, social and health workers need the excellent clinical skills required for assessment, counselling, and consultation to help service

users. Better co-ordination of services can make more effective use of limited service resources. However, the approach potentially contends with two problems. One is the allocation of resources needed to facilitate communication between health and social workers. The other is the logistic problems commonly found in collaboration arrangements, such as differences in professional orientation, administrative issues, and isolation. On the other hand, a spirit of team-work, liaising with others, as well as autonomy, challenge and work variety, may provide more satisfaction for health and social workers.

The question now is how such intrinsic attractions are sufficient to sustain the staff in their role when they are faced with such a welter of environment.

In terms of tasks, increased administrative work and level of responsibility plus reduced client's contact time appeared to be at the heart of problem. Social and health workers are being moved into the position of collaborators and away from direct service provision. Joint collaboration in the HWC is causing a high degree of role conflict. The service arrangements emphasise the need for social and health workers to be trained not only to have excellent clinical skills, but also to have the ability to work within interdisciplinary teams and to understand the perspective and procedures of general community care disciplines. Cross training opportunities can be valuable.

The further discussion around the questions of how the introduction of care management is likely to increase its effectiveness are discussed in chapter five.

## Social workers' tasks(roles) in community care for elderly people

Wintersteen(1986)argues that social workers are best placed to provide leadership in the organisation of networks of support and service to facilitate the long-term care in a community. But social workers have expressed little interest in working with long-term care groups, preferring to work with more intellectually and emotionally rewarding clients. In spite of these and other difficulties, many social workers are providing a wide array of services in community care for elderly clients(Shera, 1996, p.198).

Social workers are crucial to the delivery of services in community care for elderly people in Korea, but there is little understanding of what social workers actually do. The conventional view of the social workers' role is narrow and neglects the integrative functions, for example service coordination for their clients. The Health and Welfare Centre Project now gives that social workers new opportunities to perform a variety of integrative roles. This present small scale study provides some evidence whether social workers in rural and urban areas, are required to exercise different roles or not; and how similar their roles are to those of the UK care managers. This section presents field work data about social workers' description of their allocated tasks with elderly clients, both rural and urban. The data is based on a study of 10 social workers in rural and 10 in urban settings, who are involved in the Health and Welfare Centre project. The list of social worker's tasks comes from the PSSRU experiments(Challis & Davies(1986), Challis et

al(1990), & Challis et al.(1995))(see research methodology). Information is mainly provided on social workers' tasks and resources available for community care in the two study areas.

## *Characteristics of social workers*

The mean age of social workers was about 32 years old in both urban and rural settings. During their career, urban social workers(6.9 years) were more likely than those of rural(3.7 years) to have experience in social work. The majority of social workers were women - only 3 out of 20 social workers were male. It is a commonly-held view that the typical social worker is woman. All social workers had a university level qualification for social work, except two workers with a BA degree in administration.

Table 4-4: Characteristics of Social Workers

| Category\areas | Urban | Rural | Significance |
|---|---|---|---|
| a. mean age | 32.2 | 31.7 | NS |
| b. career | 6.9 yrs | 3.7 yrs | NS |
| c. sex: * male | 1 | 2 | NS |
| * female | 9 | 8 | |
| d. qualification | | | NS |
| * social work | 9 | 9 | |
| * others | 1 | 1 | |

Notes: NS; non-significant

## *Tasks with clients*

Social workers were asked to tick the main activities they had undertaken(see table 4-5). The main activities of social

workers were intake, need assessment, and care planning at system level in both areas. The data suggested that social workers in the urban area were more active with their elderly clients than those in the rural one, affecting most tasks given in table 4-5. In particular, rural social workers were less concerned with monitoring and revisits was the case in the urban area. It might be inferred that urban social workers had more continuing responsibility for elderly clients than those in the rural area, associated with differences in caseload sizes - around 150 cases a social worker in the rural area and around 100 cases a social worker in the urban area.

Table 4-5: Social Workers' tasks with clients

| Tasks/area | Urban | Rural | Sign. |
|---|---|---|---|
| a. intake | 10 | 10 | NS |
| b. assessment | 10 | 9 | NS |
| c. care planning | 9 | 7 | NS |
| d. monitoring | 7 | 5 | NS |
| e. review visit | 8 | 6 | NS |
| f. coordinating | 5 | 5 | NS |
| g. linking resource | 8 | 6 | NS |
| h. counselling/advice | 9 | 8 | NS |
| i. social skills education | 3 | 0 | NS |
| j. advocacy | 9 | 6 | NS |
| k. group work/ activities | 1 | 1 | NS |
| l. going to bank/ financial application | 3 | 8 | .03 |

Notes: Sign.; significant, NS; non-significant

In resource management, social workers' tasks between rural and urban areas did not show big differences. Linking service resources was a more frequent task for social workers in both areas than coordinating services, partly reflecting the limited variety of resources coordinate in the areas.

Emotional support(counselling /advice and advocacy) was more likely than practical tasks(social skill education & group activities) to be involved in social workers' tasks in both rural and urban areas. Among the practical tasks, the category of going to bank/financial application was identified to be the most important single task, identified in 8 in 10 cases in rural area. Only category was significant in statistical power($p<.03$). Although categories in social skills education and advocacy were not statistically significant($p<.05$), Urban social workers were more likely to be involved than rural workers. Overall, compared with the urban, social workers' tasks allocated in the rural setting were not relatively simple. The results confirmed that social workers were not required for different tasks between countryside and the city.

*Tasks with carers*

When social workers' tasks with carers were studied, the main activities were information exchange, advocacy, emotional support and counselling, and carers' needs assessment(see table 4-6). It was noticeable that counselling was important in both rural and urban areas. This implied that the carers under considerable stress from caring work with elderly people needed emotional support. For information exchange, urban social workers(9) were more likely than the rural(7) to get in touch with carers. Advocacy was a the major social work activity in the urban area. Compared with rural social workers(6), urban social workers(10) were more likely to be involved in advocacy. Statistical significance was shown only in this category ($p<.04$) among social workers' tasks with

carers. A the possible explanations of this difference was the Korean cultural tradition, in which more rural people than urban dwellers tended not to encourage the expression of feelings about personal matters to other people.

Table 4-6: Social Workers' tasks with carers.

| Tasks/area | Urban | Rural | Sign. |
|---|---|---|---|
| a. information exchange | 9 | 7 | NS |
| b. advocacy | 10 | 6 | .04 |
| c. emotional support/ counselling | 10 | 9 | NS |
| d. carers' needs assessment | 8 | 8 | NS |
| e. education/training for carers | 0 | 0 | NS |

Notes: Sign.;significant, NS; non-significant

Much emphasis was also put on carers' needs assessment in both rural and urban areas. This activity was undertaken by 8 of the 10 social workers in both areas. There was no emphasis at all on practical services like education/training for carers.

*Tasks with formal & informal networks*

Table 4-7 sets out the data on social workers' contacts with formal and informal networks. Social workers were most frequently in contact with formal networks for information exchange and negotiation over changes in services. For negotiation over changes in service, urban social workers(9) were more often likely than rural ones(6) to contact formal networks. This implied that there were relatively more services in formal urban networks than rural ones to provide for changing needs of elderly people.

Table 4-7: Social Workers' tasks with formal & Informal network

| Tasks/area | Urban | Rural | Sign. |
|---|---|---|---|
| **A. formal networks** | | | |
| a. information exchange | 8 | 8 | NS |
| b. negotiation over change in service | 9 | 6 | NS |
| **B. With informal networks** | | | |
| a. develop new resources | 5 | 6 | NS |
| b. linking informal resources | 8 | 4 | NS |
| c. training/ education volunteer | 0 | 1 | NS |

Notes: Sign.;significant, NS;non-significant

In social workers' tasks with informal networks, linking informal resources(8) was most frequently performed by urban social workers, followed by the development of new resources(5). The development of new resources(6) was more emphasized than linking informal resources(4) by rural social workers, probably because there were not enough services to meet elderly clients' needs in rural area. Training/ education of volunteers was performed by no social workers in the HWC in urban area, because the task was mainly performed by a training centre. In general, a client-service linchpin(linking services) was more performed by social workers than by support from informal networks(such as the training of a volunteer). No categories were significant in statistical power($p<.05$) among social workers' tasks with informal and formal networks.

## Available resources in community care for elderly people

*Community resources*

A broad using of community resources was essential to the successful implementation of community care in the light of the UK experience. To make use of such resources, the social workers required both knowledge and skills for service environmental modification.

Table 4-8: Available community resources

| Tasks/area | Urban | Rural | Sign. |
|---|---|---|---|
| a. home help | 7 | 5 | NS |
| b. private paid help | 10 | 3 | .001 |
| c. private paid nurse | 5 | 2 | NS |
| d. night sitter | 0 | 0 | NS |
| e. volunteer involvement (neighbour) | 6 | 8 | NS |
| f. meals-on-wheels | 7 | 3 | NS |
| g. laundry service | 6 | 9 | NS |
| h. occupational therapy | 7 | 0 | .001 |
| i. transport | 5 | 4 | NS |
| j. material improvement | 4 | 4 | NS |
| k. lunch/social club | 5 | 2 | NS |
| l. hair cut | 10 | 9 | NS |

Notes: Sign.; significant, NS; non-significant

As shown in table 4-8, the main community resources mobilised by social workers in community care were from the state sector such as home help(7), meals-on-wheels(7), or hair cuts(10) in urban area. From other sectors, the services used most often were private paid help(10), followed by services which used a private paid nurse(5), transport(5), a lunch/social club(5), and material improvement(4). In general, rural social workers were less likely than urban

ones to use community resources in the majority of categories.

Only two categories, laundry and volunteer involvement (neighbour), were more used by the rural social workers than the urban. Compared with other community resources, material improvement and transport were utilized with similar frequencies by social workers in both areas, while private paid help and occupational therapy were strikingly more used by the urban social workers than the rural. Statistical significance was shown by the Fisher Exact test(Chi-square) in these two categories($p<.001$). Even though only two categories were statistically significant, it seemed that rural social workers used more restrictive community resources than those urban workers. Thus the use of community resources as a method of intervention depended on the existing resources. Due to scarce community resources for services in the countryside, the social workers might take a role in reducing elderly clients' temporary discomforts, such as with hair cuts and laundry service.

*Residential and the NHS resources*

Table 4-9 summarises the main residential and the NHS resources frequently used by social workers in community care. The most significant residential resource appeared to be a non-paid nursing home in both areas(8 in rural & 9 in urban), which reflected a particularly close working arrangement with the local office negotiated by social workers. Although all residential resources were not frequently used in both areas, they were relatively more mobilised by urban than rural social workers. In the rural

area, a group home, sheltered housing, or a day care centre was never arranged by social workers for elderly clients.

Table 4-9: Available residential & NHS resources.

| Tasks/area | Urban | Rural | Sign. |
|---|---|---|---|
| **A. residential resources** | | | |
| a. group home | 3 | 0 | NS |
| b. sheltered housing | 2 | 0 | NS |
| c. private nursing home | 3 | 1 | NS |
| d. non-paid nursing home | 9 | 8 | NS |
| e. day care centre | 3 | 0 | NS |
| **B. NHS resources** | | | |
| a. GPS | 8 | 9 | NS |
| b. district nurse | 9 | 6 | NS |
| c. hospital | 5 | 4 | NS |

Notes: Sign.; significant, NS; non-significant.

The most important single NHS resource with whom the social workers were in contact was the GPs in the rural(9) and district nurses in the urban area(9). Apart from contacts with these service personnel, there was a moderate degree of social workers' contact with hospitals(5 in urban & 4 in rural). Improved liaison with the NHS resources was likely to be one of the most crucial developments in community care for elderly people.

## System factors

The questions were designed to identify the method by which social workers initially got in touch with their elderly clients for case finding; and the autonomy shown when social workers influenced decision-making for providing services. The Chi-square test was used to investigate differences between the rural and the urban areas. This indicated that no variables were significant in statistical power($p<.05$).

As seen in table 4-10, most social workers found cases by visiting/phoning and home visiting. About 1 in 2 cases was found by social workers home visiting or phoning/visiting. Only one rural social worker used a category of informal resource. The data indicates that elderly clients preferred to get directly in touch with social workers rather than by any other middlemen or mechanisms.

Table 4-10: The most useful source of information in respects of clients' intake

| Category/area | Urban | Rural |
|---|---|---|
| a. client's visiting /phoning | 4 | 5 |
| b. home visiting | 6 | 4 |
| c. other agencies | 0 | 0 |
| d. informal source | 0 | 1 |

Notes: Chi-S;1.5, Non-significant

Table 4-11: Social Worker 's influences to decision-making for services allocation

| Category area | Urban | Rural |
|---|---|---|
| a. 100% | 4 | 1 |
| b. 75% | 4 | 4 |
| c. 50% | 2 | 5 |
| d. 25% | 0 | 0 |
| e. 0% | 0 | 0 |

Notes: Chi-S;3.0, Non-significant

In order that social workers might increase and develop a range of solutions to meet clients' needs, they need direct control of resources(Challis & Davies,1986,p.9). Especially in developing a care plan, a social worker is involved in a resource allocation process involving a range of decisions about how many and what kinds of services a client will receive from service providers. Table 4-11 indicates social workers' bureaucratic power similar between rural and urban.

All social workers had autonomy on more than half of their decisions for services allocation. Four in 5 urban social workers and 2 in 5 rural social workers answered that they took charge of two-thirds of the decisions for services allocation. From the table, it was assumed that urban social workers were not more likely than rural ones to be permitted flexible responses to clients' needs.

## Summary and discussion of findings

Social workers involved in community care played several important facilitative roles with clients, carers, involved in formal and informal networks, and using community, residential and the NHS resources in Korea.
In terms of roles(tasks) with elderly clients, social workers associated several roles at the system and client levels. At the system level, as discussed in a previous subsection, social workers undertake several tasks related to the process of providing services in community care. On the basis of the results of the field research(see table 4-5), a social worker as a processor, charged with the process of community care interventions, and as a broker/an advocator, involved in selecting appropriate service networks and resources for the best package of service or support, was most required in both rural and urban areas. At the client level, social workers focused on the tasks related to direct work with elderly clients in community care. In both areas, a social worker acted as a counsellor to support the self-advocacy of clients and the movement towards higher levels of self-direction. In considering the statistical difference between rural and urban areas in the category of going to a bank/financial

application, which was one of most frequent involvements in working with rural elderly clients, a rural social worker was more likely than the urban to be weaken acting as an instructor, teaching rural clients problem-solving skills. In the analysis of working with carers(table 4-6), advocacy and counselling were the leading roles of an urban social worker. Regarding statistical significance($p<.04$), compared with rural social workers, urban workers demonstrated a frequent advocacy role, coaching clients through the maze of service procedures and encouraging them to take purposeful action to improve their condition through self-advocacy. A social worker acting as a counsellor in rural was required rather more than any other role in working with clients' carers.

In working with formal and informal networks(table 4-7), an administrator/information specialist role was also important in both areas. The social workers were often in the unique position of knowing exactly where to guide the elderly clients to make his/her impact on the system more effective. A social worker as a linkperson was required in the urban area in order to assure the service utilisation. On the other hand, a social worker as a service developer was most required in the rural area because of a lack of services to meet clients' needs.

With resource management, there were some regional variances between rural and urban(table 4-8 & 4-9). In the urban area, there were a variety of services in all categories, including residential and NHS resources used by social workers. A social worker as a coordinator was more required than as a broker. In the rural area, some categories of service resources were heavily used by social workers.

Therefore a social worker as a broker, selecting service resources for elderly clients was the most suitable role. Concerning social workers' autonomy for service allocation (table 4-11), a social worker was required as a resource allocator with responsibility for service allocation involving multiple providers in a local service delivery system in both areas.

## THE NEEDS OF ELDERLY PEOPLE AND THEIR CARERS

Most Korean elderly people receive the care they need from family members rather than from community agencies. Family care is often provided by only one carer per elderly person. As discussed in chapter one, it is becoming more difficult for elderly people to obtain caring services from family members because of changing family patterns and attitudes to elderly people. Also more women's work participation is removing those who have taken previously a main role in caring. Therefore, the necessity for the development of community care for elderly people has increased. This section considers results of the research into the needs of elderly people and their carers. 'Elderly people' means people who aged 65+ and who need some help in day-to-day activities from other *people. 'Need' means that somebody* requires help from a mechanical aid or another person. A 'carer' is someone who is aged 18+ and who is taking care of elderly people in their home.

### The needs of elderly people

The questions were designed to obtain information about the

needs of elderly people from four groups: 10 elderly people cared for by family(ECF) and 10 of cared for by community care(ECC) in both urban and rural areas. The questionnaire based on the PSSRU works(Challis & Davies(1986) and Challis et al(1995)) and *General Household Survey: people aged 65 and over*(OPCS,1991) was used(see research methodology). The information included their circumstances in general; the extent to which they had difficulty in getting about and looking after themselves in daily life; health problems, and need satisfaction; and attitudes to the welfare services.

*Characteristics of the elderly people*

The mean age varied from 77.5 of the ECF group in the rural area to 78.7 of the ECC group in the urban area. As be expected, there were more women than men in this study. Table 4-12 shows that women constituted almost two-thirds of the elderly people. The ECC groups(rural(8) & urban(9)) were markedly more likely than the ECF groups(rural(3) & urban(6)) to be widowed/divorced. Urban elderly people(ECF(6) & ECC(9)) were more likely than rural ones(ECF(3) & ECC(8)) to be widowed/divorced in the samples. Age and marital status were important determinants of the types of household in which elderly people lived. The ECC groups (rural(7) or urban(4)) were more likely than the ECF groups(0 in both areas) to be living alone. Within the ECF groups, the proportion of urban elderly people(2) was likely to be similar to that of rural peers(3) in the category of living with their spouse. However, urban elderly people(5) were more likely than the rural(3) to live with other relatives, for example, a second married son, unmarried daughters, and grand children.

Table 4-12: Characteristics of elderly people

| Category/area Group | Urban ECF | Urban ECC | Rural ECF | Rural ECC | Sign. |
|---|---|---|---|---|---|
| a. mean age: | 78.5 | 78.7 | 77.5 | 78.5 | NS |
| b. sex: | | | | | |
| * male | 4 | 3 | 4 | 4 | NS |
| * female | 6 | 7 | 6 | 6 | |
| c. marital status: | | | | | |
| * married | 4 | 0 | 6 | 1 | .05 |
| * single | 0 | 1 | 1 | 1 | |
| * widow/divorced | 6 | 9 | 3 | 8 | |
| d. household composition | | | | | |
| * living alone | 0 | 7 | 0 | 4 | .007 |
| * with spouse | 2 | 0 | 3 | 1 | |
| * with spouse,eldest married son | 2 | 0 | 4 | 0 | |
| * with other relatives | 5 | 2 | 3 | 3 | |
| * with non-relatives | 1 | 1 | 0 | 2 | |
| e. tenure of dwelling | | | | | |
| * owner occupier | 5 | 0 | 8 | 2 | .01 |
| * private rented(monthly) | 2 | 4 | 0 | 4 | |
| * private rented(yearly) | 3 | 4 | 2 | 1 | |
| * council rented | 0 | 0 | 0 | 1 | . |
| * others | 0 | 2 | 0 | 2 | |

Notes:ECC:cared by community care, ECF:cared by family, Sign.:significant, Chi-s.: Chi-square value, NS; non-significant

Among all groups, the rural ECF group(8) was most likely to have their own accommodation. It was a higher proportion than that of the urban ECF group(5). As to private rented accommodation, the ECC groups(urban(8) & rural(5)) were more likely than the ECF groups (urban(5) & rural(2)) to use it. Overall, rural elderly people were more likely than the urban to live in their own accommodation, while urban elderly people were more likely to live in private rented accommodation.

*The personal activities of daily living(PADL) and the instrumental activities of daily living(IADL)*

Informants were asked whether they could manage some aspects of personal activities of daily living(PADL): self care actives, such as washing oneself, bathing, and dressing; their mobility in home and outside, such as using the toilet and getting to bed; and miscellaneous activities, such as managing toenails and collecting letters/phoning.

As seen in table 4-13, the ECF groups were more likely than the ECC groups to have difficulties in self care activities. Urban elderly people were also more likely to need help for the same activities. In bathing, there were statistically significant differences among the groups($p<.05$). In mobility in home and going outside, the ECC groups were less likely than ECF groups to be in need of help. More than 8 respondents in all groups said that they needed some help to go outside. Therefore, they were probably unable to do their own shopping without help from another person.

Needs of mobility in the home included getting up from bed and using the toilet. The informants of the ECF group between rural(4) and urban(4) show the same proportion in the two categories of getting up from bed and using toilet. Within the ECC group differences between rural and urban were not significant.

Responding to questions on miscellaneous activities, the ECF groups both rural and urban were more likely than the ECC groups to need some help. The ECF groups in both areas(4) showed the same number of responses in managing toenails and collecting/ phoning.

In addition to questions about the PALD, elderly people were asked questions about instrumental activities of daily

living(IADL). The proportions needing help with domestic tasks widely varied from 2 respondents needing help for light housework to 10 informants needing help for shopping.

Table 4-13: The PADL & the IADL

| Category/area | Urban | | Rural | | |
|---|---|---|---|---|---|
| Group | ECF | ECC | ECF | ECC | Sign. |
| **A. personal activities of daily living** | | | | | |
| a. washing itself | 4 | 2 | 4 | 1 | NS |
| b. bathing | 7 | 4 | 5 | 1 | .05 |
| C. dressing | 4 | 3 | 4 | 1 | NS |
| d. going outside | 8 | 9 | 9 | 8 | NS |
| e. get up from bed | 4 | 3 | 4 | 1 | NS |
| f. using toilet | 4 | 1 | 4 | 2 | NS |
| g. mobility in home | 5 | 2 | 5 | 3 | NS |
| h. managing toenails | 4 | 1 | 4 | 1 | NS |
| i. collecting/phoning | 4 | 1 | 4 | 2 | NS |
| **B. instrumental activities of daily living** | | | | | |
| a. light housework | 5 | 3 | 6 | 2 | NS |
| b. making drinks/snack | 3 | 3 | 6 | 3 | NS |
| c. preparing meals | 2 | 3 | 6 | 2 | NS |
| d. heavy housework | 9 | 10 | 10 | 10 | NS |
| e. shopping | 10 | 9 | 8 | 7 | NS |
| f. laundry | 4 | 4 | 6 | 3 | NS |

Notes:ECC:cared by community care, ECF;cared by family
Sign.; significant, NS; non-significant

The ECC groups both rural and urban were less likely than the ECF groups to have difficulty with light housework - making a drink/snack, and preparing meals. In the rural area the ECC group was more likely than the ECF group to be independent for these activities.

Other important domestic activities not considered so far were heavy housework and shopping, which might most require help. Almost all respondents were having difficulty with shopping and heavy housework without help or support. With using a laundry, a similar proportion of informants were shown between rural and urban elderly people. In the rural

case, the ECF group(6) was twice as high as the ECC group(3) in need of laundry service.

*Physical and mental health*

Mental health problems as well as physical health problems were asked about. A 'health problem' was defined as illness, disability or infirmity, and acute sickness as the restriction of normal daily activities. These measures were based on elderly people's own assessment of their health. this might reflect some change in elderly people's expectations of their health as well as in the prevalence or duration of sickness.

In eyesight difficulties, as shown in top of table 4-14, the ECC groups in both areas were less likely than the ECF groups to have a problem. Elderly people living in the rural area(ECF(5) & ECC(7)) were more likely than the urban dweller(ECF(3)& ECC(4)) to say they had problem. As for hearing difficulties and speech problems, it was observed that the ECC groups were more likely than the ECF groups to say that they had difficulty with these categories. These did not show any significant differences between rural and urban elderly people. With urinary and faecal incontinence, the ECF groups were slightly more likely than those of the ECC groups to need help. Rural elderly people were less likely than the urban groups to have these problems. However, in the rural, the proportion of the ECF groups was shown to be significantly higher than the ECC group in these two categories.

Only the category of risk of falling showed statistical significance by Fisher's Exact Test($p<.05$). More rural

elderly people than the urban were at risk of falling, especially the rural ECF group(8) which was at higher risk than any other groups, while urban elderly people were suffering more from breathlessness than the rural ones. In both areas, the ECF groups were similar to the ECC groups in having a breathlessness difficulty. In relation to mental health, table 4-14 shows that the ECC groups were more likely than the ECF groups to have high scores in the categories of depressed moods and loneliness in both areas.

Table 4-14: Physical & mental health

| Category/area Group | Urban ECF | Urban ECC | Rural ECF | Rural ECC | Sign. |
|---|---|---|---|---|---|
| **A.physical health** | | | | | |
| a. eyesight difficulty | 3 | 4 | 5 | 7 | NS |
| b. hearing difficulty | 5 | 3 | 3 | 4 | NS |
| c. speech problem | 3 | 3 | 5 | 2 | NS |
| e. urinary incontinence | 3 | 3 | 4 | 1 | NS |
| f. faecal incontinence | 3 | 3 | 3 | 0 | NS |
| g. risk of falling | 5 | 2 | 8 | 3 | .03 |
| h. breathlessness | 5 | 5 | 3 | 3 | NS |
| **B. mental health** | | | | | |
| a. depression | 4 | 8 | 3 | 8 | .03 |
| f. loneliness | 7 | 10 | 3 | 6 | .01 |
| c. confusion | 3 | 4 | 3 | 5 | NS |
| d. memory loss | 4 | 6 | 4 | 7 | NS |
| e. comprehension | 4 | 4 | 1 | 3 | NS |

Notes: ECC; cared by community care, ECF;cared by family
Sign: significant(Fisher exact value), NS: none-significant

The results were statistically significant($p<.03$ & $p< .01$). In depression, area differences did not show. The ECC groups were more likely than the ECF groups to need support. A similar trend was shown in loneliness. Urban elderly people(17) were more likely than the rural ones(9) to feel differently in this category.

In the categories of confusion, memory loss, and

comprehension, the ECC groups slightly showed higher proportions than the ECF groups in both areas. Similar proportions were shown between rural and urban elderly people in confusion and memory loss. Otherwise, urban elderly people(8) were more likely than rural ones(4) to have a problem of comprehension.

*Needs satisfaction and attitude to welfare service*

Table 4-15 records that half of the respondents were satisfied with formal caring services. Five in 10 elderly people were satisfied with the community care services they were getting in both areas. It was significant that 2 in 10 urban informants clearly expressed their dissatisfaction. More than half of the interviewees(6 out of 10)who were receiving care/support from only informal carers were likely to be satisfied with the services.

All the elderly people were asked whether they wished to obtain a range of health and social services in community care, such as home help, home visiting nurse, meals-on-wheels, etc.. About seven out of 10 in all groups had a negative view of getting some services from outside of the family.

In responses of the reason why elderly people had a negative view of getting services from agency/other people, rural elderly people were more likely to answer 'no need' and 'damages their reputation', while urban elderly people were more likely to report 'burden on getting service' and 'family doesn't like'. Compared to the ECF groups in both areas, the ECC groups were reported greater difficulty in obtaining a service.

Table 4-15: Needs satisfaction & attitude to services

| Category/area Group | Urban ECF | Urban ECC | Rural ECF | Rural ECC | Sign. |
|---|---|---|---|---|---|
| a. formal care: | | | | | NS |
| * satisfied | | 5 | | 5 | |
| * so so | | 3 | | 5 | |
| * not satisfied | | 2 | | 0 | |
| b. informal care: | | | | | NS |
| * satisfied | 6 | | 6 | | |
| * so so | 4 | | 4 | | |
| * not satisfied | 0 | | 0 | | |
| c. to get/getting services from agency/other people | | | | | NS |
| * positive | 3 | 3 | 4 | 3 | |
| * negative | 7 | 7 | 6 | 7 | |
| d. if negative, the reason why ? | | | | | .004 |
| * no need | 3 | 1 | 1 | 1 | |
| * burden on getting service | 0 | 3 | 2 | 4 | |
| * family does not like | 1 | 0 | 3 | 0 | |
| * damages their reputation | 3 | 2 | 0 | 2 | |
| * others | 0 | 1 | 0 | 0 | |

Notes:ECC;cared by community care, ECF:cared by family .

## The needs of carers

Information was collected from carers living with elderly people both in urban(10) and rural(10) areas. The questionnaire based on *General Household Survey: informal carer*(OPCS,1985) and the PSSRU experiments(Challis & Davies (1986) and Challis et al(1995)) were designed to ask about(see research methodology): characteristics of carers; their activities; consequences of care in carers' lives; need for coping and caring skills; and attitudes to elderly people cared for.

*Characteristics of carers*

Table 4-16 showed that women(rural(6) & urban(9)) were more likely than men(rural(4) & urban(1) to be looking after and providing services for elderly people. In the urban area, a higher proportion of women than men were involved in caring work for elderly people in their own home. The mean age of the rural carers(46.7) was slightly higher than that of the urban carers(45.6).

Table 4-16: Characteristics of carers

| Category/area | Urban | Rural | Sign. |
|---|---|---|---|
| a. gender: | | | NS |
| * male | 1 | 4 | |
| * female | 9 | 6 | |
| b. mean age: | 45.6 | 46.7 | NS |
| c. marital status: | | | NS |
| * married | 8 | 9 | |
| * single | 1 | 1 | |
| * missing/divorced | 1 | 0 | |
| d. employment status | | | NS |
| * unemployed | 7 | 6 | |
| * employed | 3 | 4 | |
| e. relationship to elderly people | | | NS |
| * spouse | 4 | 5 | |
| * son/daughter in law | 5 | 4 | |
| * daughter | 2 | 0 | |
| * sister/brother | 0 | 0 | |
| * other relatives | 0 | 2 | |
| * non-relatives | 0 | 0 | |
| f. mean number of secondary carers | 1.8 | 1.4 | NS |
| g. type of help from secondary carer | | | NS |
| * direct help | 4 | 5 | |
| * finance | 5 | 1 | |
| * decision making | 2 | 1 | |
| * others | 0 | 3 | |
| h. mean number of hours per day caring | 7.4 | 5.4 | NS |

Notes: Sign.;significant, NS; non-significant

Married people(rural(9) & urban(8) were considerably more

likely than single or missing/divorced people to be carers for elderly people living with them in both areas. About one-thirds of the carers had part-time or full time jobs outside home. There is no big difference in carers' employment between rural(3) and urban(4).

About half of son/daughter-in-law and spouses of elderly people reported that they were carers in both areas. One in 5 carers was a daughter in the urban area. One in 5 were other relatives in rural. There was no big difference in the mean number of secondary carers between rural(1.4) and urban(1.8). In the rural area, direct help(5) from secondary carers was remarkably higher than any other help. In the urban area, in addition to direct help, financial aid was the highest proportion of the types of help from secondary carers. In the mean number of hours a day in the care of elderly people, carers were devoting nearly 6 hours a day. Urban carers(7.4) were more likely than rural carers(5.4) to be spending hours for caring activities.

*Activities*

Table 4-17 shows the proportions of activities in three main categories: heavy demanding help, such as personal care, physical help, and other practical help; help for refreshment, such as keeping company and taking out; light demanding help, such as medication or paper work. In terms of heavy demanding help, about two-thirds of the carers(rural(7) & urban(6)) helped their elderly dependents with personal care activities, such as washing and dressing. The same proportion of urban(7) and rural carers was shown in physical help such as getting into bed. Urban carers(10) were more likely than rural(8) to give their elderly dependants other practical help, for example,

preparing meals, and shopping.

Table 4-17: Activities of carers

| Category/area | Urban | Rural | Sign. |
|---|---|---|---|
| a. help with personal care | 6 | 7 | NS |
| b. physical help | 7 | 7 | NS |
| d. other practical help | 8 | 10 | NS |
| e. keeping her/him company | 7 | 7 | NS |
| f. taking out | 5 | 5 | NS |
| g. medication | 6 | 5 | NS |
| h. keeping an eye on him/her | 10 | 9 | NS |
| c. helping with paper work | 9 | 8 | NS |

Notes: Sign.; significant, NS; non-significant

In help for refreshment, any differences between rural and urban were not shown in the categories of taking out(5) and keeping them company(7). In the light demanding help category, urban carers were slightly more likely than rural to give help with all categories of medication, keeping an eye on, and helping with paper work. All categories did not show any significant differences in statistical power($p<.05$).

*Consequences of care in carers' lives*

Table 4-18 compares the consequences of care in carers' life. The comparison between rural and urban was relevant to the problems and difficulties of carers, which included personal, social, financial aspects, and changes in family routine. In personal aspects, almost all carers(rural(9) & urban(10)) considered 'unable to relax' as the major difficulty experienced. Loss of sleep was perceived by three-fifths of urban carers and two-thirds of the rural carers as one of the serious consequences of caring activities.

Table 4-18: Consequences of care in carers' life.

| Category/area | Urban | Rural | Sign. |
|---|---|---|---|
| **A. personal aspects** | | | |
| a. physical health problem | 1 | 1 | NS |
| b. loss of sleep | 6 | 4 | NS |
| c. unable to relax | 10 | 9 | NS |
| d. feelings of depression | 0 | 4 | .04 |
| e. life satisfaction | 3 | 4 | NS |
| f. used psychotropic medication | 1 | 2 | NS |
| **B. social aspects** | | | |
| a. restriction on contact with friends & family | 7 | 8 | NS |
| b. restriction on church/ club attendance | 6 | 3 | NS |
| c. restriction on time spent in hobbies | 5 | 2 | NS |
| d. restriction on time spent relaxing | 4 | 5 | NS |
| **C. changes in family routine** | | | |
| a. space | 1 | 0 | NS |
| b. family conflicts | 4 | 2 | NS |
| c. sensitive communication between elderly people and family member | 2 | 4 | NS |
| **D. financial aspects** | | | |
| a. remodel house for elderly people | 0 | 2 | NS |
| b. spent money for supportive services | 10 | 7 | NS |
| c. stop working for the care of elderly people | 2 | 0 | NS |

Notes: sign.; significant, NS; non-significant

With feelings of depression and life satisfaction, two in 5 rural informants complained, a higher proportion than the urban carers.

In terms of social aspects, there were significant differences between rural and urban carers in restriction of social activities. Rural carers(3) reported substantially lower levels of restriction than urban carers(6) for the

indicator of church and club attendance.
With changes in family routine, urban carers(4) were more likely than rural(2) to experience family conflicts. In sensitive communication between elderly people and family members, the reverse trend was seen.
In financial matters, rural carers(7) were less likely than urban(10) to have to spend money for supportive service for elderly people. Overall, actual differences between rural and urban carers were fairly small. Only one category, feelings of depression, indicated statistical significance ($p<.04$).

*Needs for coping and caring skills*

The results, as shown in table 4-19, indicated no statistically significant differences between rural and urban carers($p<.05$). Findings showed that rural carers were more likely than urban to need medical services, GPs and a visiting nurse service for coping, while in need of a nursing home, financial support, and respite care, there were higher proportions of urban carers than rural.
There were similar differences in meeting psychological needs with a counselling and carer support group.
The results showed that the most important needs of urban carers was the education video(7), followed by written material about caring(6). Compared with other services, medication and behaviour management skills were considered by urban carers as minor needs.
Rural carers also were more in need of secondary material, such as education video(4) and written material(5) than in need of direct services, such as training workshops(2), medical skills(1), and behaviour management techniques(3).

In general, urban carers were more likely than rural to be in need of almost all categories.

Table 4-19: Needs for coping and caring skills

| Category/area | Urban | Rural | Sign. |
|---|---|---|---|
| **A. needs for coping** | | | |
| a. GPs | 4 | 6 | NS |
| b. visiting nurse service | 4 | 7 | NS |
| c. day/overnight services | 5 | 3 | NS |
| d. day/overnight respite care | 4 | 4 | NS |
| e. home help | 1 | 3 | NS |
| f. private care service | 1 | 0 | NS |
| g. nursing home | 2 | 0 | NS |
| h. secondary helper | 5 | 4 | NS |
| i. voluntary service | 3 | 2 | NS |
| j. financial support | 4 | 3 | NS |
| k. carer support group | 3 | 2 | NS |
| l. counselling/moral support | 6 | 5 | NS |
| m. telephone hotline | 2 | 3 | NS |
| **B. needs for caring** | | | |
| a. education videos | 7 | 4 | NS |
| b. training workshop | 3 | 2 | NS |
| c. written material about caring | 6 | 5 | NS |
| d. behaviour management technique | 2 | 3 | NS |
| e. medication skill | 3 | 1 | NS |

Notes: sign. Significant, NS; non-significant

*Attitudes to caring for elderly people*

Questioned on the reason why they were caring for elderly people(table 4-20), about two-thirds of the informants reported a sense of duty (family relationship) in both areas. Some respondents (rural(2) and urban(2)) said they were taking care of elderly people because 'there is only me'. Compared with urban carers(1), rural carers(3) were a higher proportion in the category of reciprocity. Little significant difference were shown between rural and urban in all categories.

Table 4-20: Attitude to caring for elderly people

| Category/area | Urban | Rural | Sign. |
|---|---|---|---|
| **A.the reason why you are caring for elderly people** | | | NS |
| a. family relationship (sense of duty) | 6 | 6 | |
| b. there is only me | 2 | 2 | |
| c. I love her/him | 3 | 1 | |
| d. reciprocity | 1 | 3 | |
| e. emotional reward | 0 | 0 | |
| f. religious motivation | 0 | 0 | |
| **B. attitude towards caring** | | | NS |
| a. happy helping | 1 | 1 | |
| b. accept it | 5 | 8 | |
| c. can't seem to get through to him/her | 3 | 1 | |
| d. ties me down completely | 1 | 0 | |

Notes: sign.; significant, NS; non-significant

with attitudes to caring for elderly people, more than half of the carers interviewed said they 'accepted it'. Rural carers(8) were likely more than urban(5) to accept the caring responsibility. On the other hand, a negative attitude, 'can't seem to get through to him/her' and 'ties me down completely', was expressed by more urban carers(4) than rural(1).

## Summary and discussion of findings

*The Needs of elderly people*

As would be expected, there were more elderly women than elderly men in the sample. It is well known, in general, women live longer than men(OPCS,1991,p.1).

Marital status was obviously one of the important

determinants of the type of household in which elderly people lived. The elderly people cared by family(ECF) groups appeared as a higher proportion in the category of married and living with another person, while a significantly higher proportion of the elderly people cared by community care(ECC) groups were in the category of the widow/divorced and living alone. A possible explanation for group differences was that a necessary condition to receive community care services from the HWC was the elderly people had to live alone in his/her household.

For most elderly people, old age is characterised by a gradual physical deterioration over time, as a result of which mobility becomes increasingly restricted. Whatever the pattern of physical decline, the first point at which restricted mobility becomes a real inconvenience is when it prevents elderly people from managing themselves in home or outside. As field research showed with some evidence, the situation with the personal activities of daily living(PADL) and instrumental activities of daily living(IADL) needs appeared to indicate differences between the ECF and ECC groups, even if many of these were not supported by statistical significance($p<.05$). In general, the ECF groups were more likely than those of the ECC groups to be in need of help in the IADL and PADL. It might be that the ECF groups had been provided with caring services to meet their concomitant needs by a member of the family, but that the services were inadequate to meet elderly people's needs.

The findings underlined the importance of providing appropriate services for elderly people. This would have implications for interventions to address specific areas of need. A possible intervention is to provide the education/

skills of caring for carers. For the IADL & PADL needs of the ECF group, on the other hand, increased availability of formal services appears to be indicated. Another explanation was that the effects of the IADL & PADL needs depended very much on elderly people' circumstances. We could regard dependency of elderly people as one of the reasons why the ECC groups were more likely than those of the ECF groups to be able to manage their own individual lives. It meant in part that although the ECC groups had been provided with community care services by the HWC, the services were not enough to meet their needs in daily living. Therefore, they had to manage many aspects of their own daily living activities. The ECC groups tended to be more hardy individuals, more independent than the ECF groups, which could obtain the necessary care or help from carers who lived with them, as needed.

There was little evidence in the data to suggest that rural elderly people were dramatically different from urban individuals in needs of the IADL and PADL. However, it is highly likely that travel distances and transportation problems in a long or cold winter led rural elderly people to have difficulty in the IADL needs, especially shopping. In discussion of elderly people's physical and mental health, there was evidence to support a convincing link between the ECC groups and poorer mental health. The findings showed that mental health need was consistently greater in the ECC than in ECF groups. The explanations are, first of all, poverty might or might not play a role. The cash available to ECC groups seemed to be less than that to ECF groups. Second, the ECC groups received limited emotional support from family members or relatives, since a majority of the ECC groups

lived in a lone elderly people household.

In spite of disparities in the distribution of health resources, the volume and pattern of need of physical & mental health of rural and urban elderly people did not differ greatly. However, there was a significant difference between rural and urban respondent in the category of risk of falling in physical health and loneliness in mental health. According to the results of the survey, rural elderly people had more risk of falling than those of urban. One of the possible explanations of the difference was the structure of houses. There were more unmodernised houses in rural than in urban situations.

Concerning needs satisfaction, two in ten informants of the ECC group in the urban area clearly expressed their dissatisfaction with formal services. Two possible explanation are that the current community care services have not provided on the basis of needs-based assessment, and that there are a little services available to use in the area. We had to be careful in the interpretation of the answer 'so so', since in terms of Korean culture, one said 'so so' when she/he was not satisfied with something, but did not want to complain. Therefore, the answer 'so so' of the ECC groups(urban(3) & rural(5) could be regarded as not satisfied with formal services. As would be expected, a nil answer of the ECF groups, both rural and urban, was given to 'not satisfied with informal services'. It could also be explained in the light of Korean culture. Elderly people did not usually want other people to know their family matters. To talk outside the family about the fact that certain elderly parents were not satisfactory provided with care/support by their offspring, elderly people would think that it made them

and their offspring suffer some damage to their reputation.

*The needs of carers*

Although it is well-known that the public image of carers is as predominantly a women's group, little is known about the population of carers in Korea. In this study, son/daughter-in-law was one of the most frequent carer groups, a finding that was consistent with those of earlier studies(Choi,1991 & Lee et al.,1994). It is common that the first son/his wife is mainly charged with the care of elderly parents because of the long-standing tradition of filial piety by primogeniture in which it has always been the first son and his wife's responsibility to care for parents in old age(Choi,1991,p.2). There is no question that a family member predominantly the daughter-in-law, is still the principal source of caring for elderly people in Korea. The data also revealed that roughly half of the carers were spouses, a finding which also supported previous research results showing that the informal care system was partially composed of young-elderly carers for the care of old-elderly people in Korea. The phenomenon may be accelerated by the increase in the number of elderly people in need of care/support increased, accompanied by a reduction in the number of available young women to provide care, partly because of demographic and social changes(see chapter 1).

A substantial proportion of carers in this research were juggling familial and employment responsibilities which placed competing demands upon them. Furthermore, carers reported spending many hours fulfilling their caring responsibility. The role conflicts may represent an even

greater challenge to future cohorts of carers. Most of the carers were depicted as sharing some care tasks with secondary helpers. As we expected, even urban carers were less likely to share in hands-on help, as we found that secondary helpers contributed money or help with care decisions rather than direct care. It might be said that a nuclear family system was prevalent in the urban area.

The study confirmed the findings of previous studies which have documented the high need of formal care or support for carers. The nature of the elderly relative's caring was considered to be a chronic burden for carers. The findings suggested that carers primarily experienced burdens in the areas of mental health(unable to relax) in personal aspects, social participation(restriction on contact with friend & family), and financial aspects(spent money for supportive services). In both areas, these categories appeared to be considerably worse burdens than any other categories. The burden was expected to differentiate between rural and urban carers in the personal, social, financial, and family routine aspects.

Contrary to expectations the results of the comparison of consequences of care in a carers' life revealed no significant differences between the two areas. The argument could be made that practical factors did not allow significant differences between the two areas. Firstly, elderly people's dependency level might significantly be related to the personal and social aspects of the carers' life. The higher the dependancy level of elderly people, the more carers had burdens. Secondly, the lack of social care facilities, for example day care centres and sheltered housing, was related to social aspect of carers' lives. As

presented on table 4-9, there were limited social care facilities available in both areas. Thirdly, the size and structure of houses were relevant to carers' stress in a family routine and involved financial aspects. As argued in chapter one, big housing in the urban area was often quite expensive so that the houses were usually too small to accommodate multi-generation families.

Similar responses emerged between rural and urban areas regarding needs for coping and caring skills(table 4-19). Carers in both areas saw value in counselling for coping and in use of written material for caring skills. The pursuit of needs for caring skills stood out as a common desire, which could lead consumers to be more empowered. Another important finding was the observation that 5 of 20 carers wanted to cease giving care and assistance for elderly dependants. This phenomenon attests to the dynamic nature of the caring process and the rapid changes which can occur within a relatively short period in Korea.

## CONCLUSION

We have discussed the characteristics and complex issues surrounding community care for elderly people in Korea. Firstly, community care as a cultural practice has been shaped by religious forces (Confucianism & Buddhism) in the long history of Korean culture. This means that community care is care by the community, particularly care by the informal networks based on a traditional caring system. Elderly people who have been cared for within the informal caring system are likely to get extended services from the state and private sectors in community care. Therefore, it

can be said that community care has been developed, not by a movement of anti-institutionalisation, but by replacement of family care. Secondly, its recent development has contained certain changes that went in tandem with the government policy. The policy emphasizes a mixed economy of care and the government largely remains in a minimum role of sustaining community care. Thus, no satisfactory recipe has been developed over 15 years of community care for elderly people in Korea. Community care for elderly people is at best a patchy scarf of resources, at worst non-existent in Korea. A clear comprehensive policy is required, which sets out the responsibilities of the various agencies and professionals involved in this field.

In addition to a literature study, the field survey has provided some interesting results. Firstly, the important point to be drawn from the field study is that there were a number of caveats to the interpretation of the results offered here. The information was based on cross-sectional data. As Bowling and Grundy (1997,p.113) argued, we should be cautious about drawing conclusions from cross-sectional data sets, since people with certain characteristics may be systematically removed. The size of the samples used in this study was constrained by the operational requirements of the parent study. Evidence of differences between samples did not emerge when assessing the statistical significance ($p<.05$), although the experiences of rural and urban lifestyles clearly differed in a variety of ways. Therefore, estimates of social workers' tasks, the needs of elderly people, and their carers were of necessity somewhat approximate. Various internal validity threats relating to the selection of participants might have resulted in the lack of observed

differences between and among the samples.

Secondly, social workers' tasks were similar to those of many UK care managers. For instance, administrative tasks such as mobilising resources were more emphasized than those of traditional social work. In the community care system in Korea, three major urgent issues pervaded, such as insufficient services to meet needs of service users, non-comprehensive and poorly understood services, and inappropriate and inflexible use of the services. Consequently, there has arisen a need to look again at the methodology of facilitation, support and extension of community care programmes.

Thirdly, all needs of elderly people and their carers could not be addressed in this study, but the study does contribute modestly to a greater understanding of the relationship between community care and the needs of elderly people and their carers in Korea(see next chapter). This study found little empirical evidence to support or refute significant differences between urban and rural elderly people, the ECF and the ECC groups, and between rural and elderly carers. The considerable needs of community care services for the ECF groups and their carers were reported. However, it was questioned that although the services were arranged by social workers for the ECF groups and their carers, would they fully use the services designed for them ? The ECF groups and their carers might easily not use such services because they were uncomfortable admitting that they needed help. The use of community care services seemed to suggest that the carers were not properly assuming responsibility for those for whom they were caring. It is required that a system and need-based approach mechanism for service delivery should

be developed to provide multiple community care services for the ECF groups and their carers in a stigma-free environment. The following chapter is to explore the implications of care management, based on findings of this chapter, in care management for elderly people in Korea.

# CHAPTER V

# THE DEVELOPMENT OF CARE MANAGEMENT IN COMMUNITY CARE FOR ELDERLY PEOPLE IN KOREA

Although Korea has achieved significant progress of services in community care, the services for elderly people still remain at an initial stage due to factors such as limited coverage, insufficient services, and a lack of funds. Furthermore, increasing numbers of potential elderly clients who need services from agencies have compelled Korea to develop community care(see chapters one & four). Such issues have led policy-makers to reassess the service delivery system to find effective ways to provide services in community care for elderly people. In this chapter, we drawn on the previous chapters in investigating need, strategies, and principles for the development of a care management as a new element/addition to the current service delivery system in Korea. In the first section, based on material in previous chapters, reasons are advanced why care management has to be developed in Korea. The second section focuses on whether UK models of care management are feasible in Korea or not. Based on findings from the previous discussions (chapters three & four), the last section suggests some principles for the development of Korean care management.

## THE NEED FOR THE DEVELOPMENT OF CARE MANAGEMENT

This section argues by what rationale care management in community care has to be developed. The growth in resources for community care for elderly people has been used to increase service levels, to extend the range of services and improve their quality. Policy makers and practitioners have started to understand issues of the nature and causes of inefficiencies, to be concerned about accountability and decentralization, and to seek better use of resources and service development. Managing and developing resources has become a more vital prerequisite of efficiency and equity in community care due to the speedy shift from family care.

### A shift from family care to community care

In recent years, community care is perceived as one way of meeting needs and filling a gap, reflecting the fact that Korean society has changed and that the state has been encouraged to share the function of elderly caring. However, the target is mainly focused on elderly who are vulnerable under the poverty line or childless(see chapter 4). Furthermore, there have been major restrictions on eligibility for state health and social care services, especially residential care for elderly people in Korea. Admission to residential care was not allowed without administrative approval, because there only existed state-run institutional care facilities for elderly people until 1980s(see chapter 4). Since the early 1990s policy-makers have recognized that issues of elderly care have become a

major social problem with institution-centered social care programs unable to address the needs of a rapidly increasing proportion of elderly people who need care. As mentioned earlier, policy-makers have noted shifts in welfare policy in western societies away from institutional care to community care. Consequently, community care for elderly people has been encouraged and regarded as one of the alternatives for traditional family care in Korea. However, there are important differences between western societies, especially the UK and Korea in this regard. In western countries, institutional care for elderly people was already fully developed by the time the shift towards community care began. In Korea the shift of policy for the care of elderly people from family care to community care without an institutional care stage was made before the infrastructure for institutional care for elderly people had been fully developed. As a result, Korea still lacks a well-established infrastructure of institutional geriatric services, for example, nursing homes, group homes, and places for elderly people whose care cannot be provided in their home. As of 1995, only 0.3% of the total elderly population stayed in institutional settings.

The number and prevalence of elderly people receiving community care has been frequently investigated by both national and local governments, but little research has been carried out on elderly people, still cared for by a family member only. This study's findings that the ECF groups are similar to the ECC groups in requiring some assistance is suggestive, even though this finding is based only on small samples in two areas in Korea.

As for the family carers' difficulties, which we include as

an independent need factor, a considerable number of carers have serious difficulties in providing necessary care for elderly people. The study results revealed that such family care is still generally the norm, but this system is under great stress even in a rural area where family care is relatively firmly-rooted. In the future, as discussed in chapter one, difficulties in providing family care are likely to increase as the size of the typical family decreases. Thus, a substantial expansion of social care service for elderly people is an unavoidable imperative in the near future in Korea. When these trends are taken into consideration, a steep upward revision of the service delivery system in community care for elderly people will be needed, and care management may be one new element/ addition to the current service delivery system.

## Decentralization and accountability

Another need for care management in community care for elderly people result from a huge shift away from centralization to decentralization. Decentralization can range from the shift of routine workloads to the devolution of powers to perform specific functions. It takes place in two ways, that is area and functional decentralization (Kim,1988, p.40).

First, area decentralization transfers authority from central to local government. Local governments in Korea have never played a major role in welfare services. They lack infrastructures for planning and delivering services. But after launching local autonomous government in 1995, local governments have been expected to assume responsibility for

developing and implementing welfare programs for vulnerable people, including elderly people. This decentralization approach allows for local governments to assess their specific welfare needs and develop welfare programs found most appropriate through their own investigations. For example, how much, for whom, what, and how services are provided is expected to vary, depending on individual local governments. The likelihood of successful development of care management may depend on how seriously local governments tackle the new innovative service delivery mechanism in community care.

Secondly, functional decentralization transfers functions and decision-making authority within the hierarchy through shifting workloads from higher to lower workers(Kim,1988, p.40). In the light of UK experience, devolved purchasing is one of the most powerful ways of developing more responsive service in community care. Care management projects in the UK(see chapter three) have shown that this approach can bring about improvement in the quality of service provided (DoH,1991a, p.17). As Sheppard(1995,p.16) argued, this enable users and carers to exercise the same power as consumers of other services. This redressing of the balance of power is 'the best guarantee of a continuing improvement in the quality of service in community care'(DoH,1991b,p.9). The functional decentralization in the process of welfare service delivery in Korea, according to Kim's argument(1988), has not received adequate attention. This neglect was partly due to the naive assumption that once policies and programs had been formulated, they had been automatically implemented by the bureaucracy and the results achieved had been those expected by policy makers(Smith, 1973,pp.197-8). However, as seen in

chapter four, field social workers in the HWC have kept considerable authority to make decisions for services. The result may partly be caused by launching local autonomous government and authority decentralization. The authority decentralization is closely 'related to accountability, which is concerned with responsibility for particular action or non-action'(Davies et al.,1990,p.164), although Adler and Asquith(1981) argued that professional decision-making is subject to particularly weak forms of public accountability (ibid). Care management seeks to develop authority to the lowest possible level by becoming directly responsible for the use of limited resources. This greater autonomy and responsibility in turn create a need for changes in accountability to ensure the maintenance of standards (Hugman, 1994,p.242). The accountability which is expected is in two directions - to the consumer and to the agency. According to Sheppard(1995), to improve accountability to the consumer, an open and available complaints procedure when they are dissatisfied with the services has to be develop in community care for elderly people(pp.13-14). Accountability to the agency occurs through 'the formal means of line management and organizational systems developed to monitor the quality of services provided' (DoH,1991;Sheppard,1995, p.14).

Challis and Davies(1986) argued that 'accountability of care management is partly achieved through vertical hierarchies and operationally defined procedures'. But system development is often piecemeal, arising in response to particular situations or difficulties. Consequently, decisions about resource allocation are often made at considerable organizational distance from the individual making the

assessment of need(p.7). The absence of clear lines of accountability is also parallelled by a lack of information procedures(Davies et al.,1990,p.165). The development of computer-based information systems makes the development of accountability more possible. Adequate management information and clear parameters to autonomy are prerequisites of the decentralizing control of resources and giving greater freedom to the social workers. Under these conditions, achieving a new balance between autonomy and accountability might permit a more effective deployment of resources to meet a need(Challis & Davies, 1986,p.8). It is expected that one of the possible ways to improve effective use of authority decentralization and accountability should be achieved by the development of care management in community care.

## Better use of services and service development

A third major need for care management is the rapid expansion of in community care services by the creation of a mixed economy of care. As mentioned in chapters one and four, the Korean government has driven policy to develop a mixed economy of care in the personal social services. Private and voluntary sectors especially have been encouraged. For example, for the period 1995 to 2000, a yearly low-interest loan of Won 10 million is available for the expansion of commercial facilities for elderly people and facilitation of private citizens' participation in the process(Shin,1997, p.6). There are presently 49 centers with home helpers providing meal preparation services, assistance in bathing, information of medical care, to all elderly people who remain unaccompanied and unsupported. By the year 2000 such centers

will have increased so that each city and county will have one (Shin,1997,p.5). As discussed in chapter 4, current services offered by the HWC are often unable to combine to meet the needs of elderly people and their carers effectively and efficiently. Services are frequently inflexible and unresponsive to elderly clients' needs and those of carers. At the same time, community health and social service staff often perform very similar tasks, which can lead to multi-interventions for some elderly clients and gaps for other. Furthermore, although current priority target groups for services in community care have been elderly people who need livelihood protection or those aged without families/other caregivers, services in community care should be expanded to include elderly people's care by the family members in the near future. A service delivery mechanism is now needed to use resources flexibly to provide the best possible care. In community care for elderly people, coordination among related organizations and agencies is not yet an important issue, especially in rural areas, because of the very limited kinds and volumes of service available for rural elderly people(see chapter 4). It may be ultimately one of the causes of unresponsive services to the changing needs of elderly clients and their carers. There is a need to develop services that provide support for elderly clients and their carers such as day care centers and residential care services. At the same time, special attention must be given on the service delivery mechanism. UK experience shows that care management is useful for designing a care package, since it provides an effective method of targeting resources and planning services to meet specific needs of individual clients(see chapter three).

## STRATEGIES FOR THE DEVELOPMENT OF CARE MANAGEMENT

Care management in the UK has been advanced as an extended attempt to revise existing patterns of services and produce more effective care for elderly clients in community care. What might result if the UK models of care management are implemented in community care for elderly people in Korea, where there is a totally different culture, socio-economic conditions, and welfare structure from the UK ? This section reviews three models of care management implemented by the PSSRU at the University of Kent in the UK(see section 3 in chapter three) and examines these models to feasibility for community care provided by the HWC for elderly people in Korea.

### The social care model(Kent)

As discussed in chapter three, the social care model is characterized by a care manager located within a single agency, especially a social service department. A care manager performs all the core tasks of care management. The care manager can directly arrange social services for the clients. The main difficulty lies in the access of other services, especially health services. The care manager is required to undertake direct work as well as indirect work with the clients and their carers.

In Korea, social workers in community care in the HWC are responsible for linking and knitting services from a variety of resources, usually using traditional personal social services such as home help services. Direct work with elderly

people is one of their most frequent tasks such as going to bank/fill in documents(see chapter four). This model stresses coherence and accountability in the delivery of services to elderly clients. Designating a single social worker as the care manager ensures that there is someone who is accountable, who helps elderly clients to hold the delivery system accountable and who cannot pass on the responsibility if services are not delivered quickly and appropriately (Miller,1993; Robert-DeGennaro,1993,p.106). If this model was tested or implemented in community care
in the HWC in Korea, findings from research suggested that the comprehensive responsibility for the cases could be assigned to social service teams, comprising social workers, team managers, and a director in the hierarchy of bureaucracy(see chapter 4). Advocacy is a strong feature of the social care model in the UK. Social workers as advocates are strongly required as one of the social workers' tasks in the HWC in Korea(see chapter 4). Clearly social workers must take a major role of working on behalf of elderly clients and their carers for more and better services and to protect clients rights. Contrary to current social workers' practice in community care for elderly people in Korea, the provider(direct services) is not emphasized in an advocacy task, which involves ensuring that others provide the needed service to elderly clients (see chapter 2).
The model demonstrates greater flexibility of services devolved budgets. The budget, set at two-thirds the cost of a place in residential care, enables social workers to access services in the independent and voluntary sectors as well as their own, and to cost each individual package of care(see chapter 3). Considering the current social service delivery

system, especially financial accountability, it seems unwise to generalize about this finance decentralization in Korea. Without consolidated financial accountability and supervision , social workers might abuse their financial powers. The separation of clients' needs assessment from the care planning and purchasing services would be necessary.
In addition, budget decentralization implemented through front-line workers requires a clear purchaser/provider split, with emphasis on the role of purchaser. In Korea the purchaser/provider separation is not clear and a social worker as the provider is a strong feature of the social worker's role in community care. A social worker as the contractor(purchaser) should be emphasized, because the private and the informal sectors in the mixed economy of care have heavily been developed in community care. With the social care model, a social worker may be delegated into the purchaser role from the social services department without the development of a supportive administrative structure from health services for social care in Korea.
As a practical model, care management focuses on the elderly clients' needs rather than on their problems. In cases where there are multiple needs, health and social care should be combined. A health and social care model is considered next.

## The health and social care model(Gateshead)

Collaboration between individuals, organizations, and professional groups has long been put forward as a prerequisite of a good comprehensive quality of services without costly duplication. In community care for elderly people, the prime concern with collaboration between health

and social services has long been noticeable to ensure that the totality of elderly people's needs is recognized and meet (Nocon, 1994,p.1). The social and health care model in the UK is managed by joint agency collaboration between a health authority and a social service department - social workers, a senior nurse,a junior doctor,and physiotherapist(see chapter three).

The need for a social and health care model in community care in Korea has been raised for a reason. As presented in the results of field research in chapter 4, there is now a considerable overlap in elderly clients's needs for health and social services. Elderly people discarded by their family members have emerged with considerable personal care needs from both social and health agencies. In my judgement, a health and social care approach is the best and most efficient model for providing comprehensive services in community care for elderly people in Korea. However, from the UK experience, we can assume that joint agency working is notoriously difficult because of the different organizational philosophies, objectives, and management culture. Therefore, as Webb(1991) argued, there are four broad requirements for joint agency collaboration in community care: 'the effective mobilization of 'self interest' as a basis for bargaining and exchange; the legitimation of wider interests and goals; the creation of a broad rather than narrow base for inter-organizational relations; and the recognition of the role and dynamics of trust'(p.238).

Since 1948 health and social services have been separately been administrated, although there has been much overlapping. With the introduction of concepts of community care, one of the major issues has been unification within each service,

and the links between the two services.

The Health and Welfare Center Project launched in 1995 has offered the opportunity to establish formal joint collaboration between health and social services for taking community care forward(see chapter four). Several benefits associated with joint collaboration have been identified by the first evaluation report of the HWCP: it helped purchase that degree of increased contact between health and social workers. Second, joint collaboration has helped to maintain community care at higher levels than would otherwise have been the case(Lee et al.,1995,p.26). However, there is a considerable amount of evidence that negotiations around joint collaboration have sometimes engendered mistrust rather than the reverse. It is clear that joint collaboration suffers from two major weaknesses. First, it can divert attention from examining the purposes to which mainstream services are put. Second, there is a lack of clarity over what joint collaboration adds.

As argued by Bebbington & Charnley(1987,p.15), a problem for the social and health care model lies in the lack of a clear lead agency to take responsibility for joint planning(see models in chapter two). Introduction of the social and health care model in care management in community care may have a major impact on mainstream care at a field level(Sargeant, 1979,p.186). The professional accountability of the field staff is ultimately to the coordinator, and for this reason a social worker is desirable for this role in the HWC in Korea, so that both professional and managerial accountability can be incorporated into one person. Each client's care needs should be negotiated with elderly people first, and then slotted in with inputs from other agencies.

Close liaison with the health care agencies needs to be developed and maintained to ensure good understanding of any care/treatments or procedures undertaken, or changes and deteriorations in a client's condition.

Commitment and receptiveness to the social and health care model are not simply a matter of establishing and reforming the formal machinery. Attention must also be given the interplay of values, interest, and environments on the individuals and organizations engaged in joint agency collaboration(ibid,p.186). Wistow's(1988) statement should be recalled order to implement successfully a social and health care model in the HWC that: 'services should be process-led rather than structure-led; its starting point should be from a consumer perspective to clarify the values and purposes which community care is intended to realize'(p.82). For the development of an excellent health and social care model in Korea, understanding of each other's role should precede the acquisition of new skills between social and health service workers. For example, if assessment for limited social care needs were carried out by health service workers, it could increase their role credibility, job satisfaction and understanding of social services roles while reducing unnecessary visits to the clients.

## The multidisciplinary team model(Darlington)

A 'multidisciplinary team' in care management is defined as:

"composed of at least three disciplines; members acknowledge they are members and know others; regular meetings for general policy and specific services; blurring of roles and sharing of responsibility; team leader identified; a care manager for each client; a care manager makes most decisions for the individual"(Cooper,1990;Sims & Sims, 1993,p.26).

The multidisciplinary team in the Darlington Project is composed of doctors, district nurses, care managers, social workers,chiropodists, home care assistants, physiotherapists, occupational and speech therapists(Challis et al.,1991, p.239). Contemporary community care, as seen in the results of the field research, mainly has to involve physical, psychological and social interventions, so that their caring requires very often a combination of two or three professionals and paraprofessionals, especially, for the care of elderly people aged over 80, whose mental and physical fragility is greatest.

In line with the current service delivery system, a multidisciplinary team can include input from a medical doctor, social workers, home visiting nurses, occupational therapists, and home helpers. But if multidisciplinary interventions were used in the current service delivery system, they would be time consuming and require a high degree of training. Operationally, we can assume some issues which affect building a team if a multidisciplinary model is implemented within the HWC. Are the team members equally responsible for team work? If not, how are their duties defined? Who is to be a team leader? Will team leadership vary according to the clients' needs? Who will accept responsibility for assuring that details of a care plan are carried out? How specific should the definition of duties be? Who will take what kind of responsibilities for liaison with other professionals and other agencies?(Gaitz,1987, pp.553-554).

Care managers (social workers) are leaders of the multidisciplinary team in the Darlington Project(Challis et

al.,1991,p.237) because their comprehensive psychological and social training in care fit them for this role. As the roles of social workers in the HWC were identified in chapter 4, the social workers have a special responsibility for shaping and leading such a team in Korea. By their training, practice, and outlook, the social worker as team leader can offer a combination of skills for dealing with clients' physical, mental, and social problems. Social workers are put under particular strain when a multidisciplinary team employs only one social worker who faces a bevy of health personnel. They feel isolated and suffer from a lack of support. For example, in a multi-disciplinary team for the care of elderly people with predominantly mental health problems, it is the social worker who is expected to challenge medicalised approaches which involve coordinating the talents of several therapists with the needs of clients(CCETSW,1989,pp.8-9).
The multidisciplinary team model in the Darlington project in the UK seeks to extend care management approaches into the realm of a joint health and social services model of provision, based upon using multi-purpose care workers to reduce overlap between personnel(Challis et al.,1991,p. 237). Multi-purpose care workers employ team members who share skills and knowledge. It is assumed that the multi-purpose care workers would be employed in a multidisciplinary team in the HWC in Korea.
This may result not merely in a change of location for the social workers involved and in the development of a fundamentally different method of working. The specific skills and knowledge of individual disciplines may be lost, while multipurpose social workers may be found to be overpowering. Therefore, the team may be ineffective in

achieving their multi-disciplinary goals(Sims and Sims, 1993,p.29). Multidisciplinary team work, especially a joint health and social service department, is a two-edged sword. The tensions and conflicts within it are also its creative force. A social worker within such a team may find him or herself living daily with differing agency interests(notably between the health authority and the social service department), complex funding arrangements, difficulties in drawing up a common philosophy because of culture clashes between disciplines, blurring of team members' roles and tasks, plus varying status and income between team members (CCETSW,1989,P.9).

Clarifying areas of responsibility and lines of accountability within the teams has been made more difficult by the unhelpful and inaccurate equation of medical responsibility with ultimate medical responsibility assumed by the team's most senior medical member. The valued notion of democratic or non-hierarchical teams has emerged partly in reaction to this unqualified hierarchy. As argued above, interprofessional rivalries may have impaired clients care and wasted resources. Unfortunately, services in community care in Korea have been no exception. A multidisciplinary team will not function effectively unless it is clearly led, its aims and functions are known and stated, and the relationships between members and disciplines of the team are unequivocal.

## Strategies for the implementation of care management

There is sufficient positive evidence from the research to suggest that certain models of care management are feasible

in community care for elderly people in Korea. But the process of translating the research findings into practice is more complex. There are many factors 'influencing the implementation of the findings over which the researcher has little or no control'(Bradley,1977,p.3). Strategies for the implementation of care management as an innovative provision have already been discussed in research methodology(see introduction) such as how and what problems/issues have to be overcome. This subsection discusses strategies regarding several major questions to be considered for the implementation of care management such as how, when, and by whom.

In terms of policy development, the central government as a planner(a policy maker) has played an important role in the development of welfare services(see chapters one and four). The central government should set goals and standards for a care management programme. But it seems unwise for the central government to attempt to exercise a high degree of control over the implementation process of care management that takes place at local level. The findings from the research(see chapters four & five, and lessons from international studies) suggest that the detailed plans to implement care management should be set up by the local authorities(at county level). A clear and simple statement regarding the central objectives of the programme should leave local authorities free to work out all of the different ways by which to implement the objectives.

In aspects of assessing clients'needs and choosing care management teams, the systemic assessment of the clients' needs prior to any form of care management intervention lies at the heart of practice in community care(see chapter two).

Local authorities(at county level) respectively are required to assess clients' needs as a means of obtaining accurate and appropriate information. It has been identified that social workers and home visiting nurses are the best groups to perform clients' needs assessment in the community. Furthermore, a care management team should consist of a medical doctor, home helpers, occupational therapists, social workers, and home visiting nurses already working in community care. Social workers are the best professionals to be care managers(see some implications in chapter two and the previous subsection).

Another issue of implementing care management applies to the training and education of care managers. The current pattern of education has been to train social and health workers in an environment designed for group learning(eg. in university/ college) and to get practical experience of clients in convenient settings for group learning(eg. a general welfare centre)(see chapter three). Some departments , for example social work & nursing courses, in universities /colleges should include care management techniques, methods, and knowledge in their curriculum. Training how to apply core components of care management in community care is currently a basic set of competencies to acquire. To set up institutions as a small-scale 'centre of care management' would be a very convenient place for health and social care staff to be trained as care managers. Action plans can be discussed through formal training programmes. These should emphasis techniques for the process of care management(eg. counselling & needs assessment), understanding the environment at the system level(eg. networking & service development), and understanding the users' environment

(social & health care knowledge)(see chapters two & three). With the issue of when the care management programme should start, this should be dependant on the local authorities circumstance. It may have to be started after the care managers' initial training. If possible, wait to implement care management until the care managers are fully trained.

## SOME PRINCIPLES FOR THE DEVELOPMENT OF CARE MANAGEMENT

The incorporation of care management principles at the system level into community care can enhance the clients' needs satisfaction through making unique contributions in providing coordination and integration among complex service delivery systems. From the international perspectives, including the UK, the main system level principles of care management can be summarized as a mixed economy of care & the purchasers /providers split, using a needs-led approach, and monitoring cost effectiveness. These principles had to be incorporated into the development of care management in community care for elderly people in Korea. These principles are first discussed according to their relevance to Korean society.

### System-level principles

*A mixed economy of care & the purchaser/provider split*

As mentioned in earlier chapter, the mixed economy of care is regarded as one of the crucial preconditions to operating care management. The mixed economy of care is a concept which

provides 'a simple organizational framework for differentiating the role of public, private, voluntary, and informal sectors in the production and financing of social care'(Judge,1987,p.27). Two points from this necessarily brief theoretical sketch need to be emphasized. First, even a normative position which gives pre-eminence to individual freedom can find room for substantial state intervention. The modern liberal favors a positive conception of freedom. Second, the form of intervention should be constrained and conditioned by an emphasis on economy, efficiency and procedural fairness (Judge,1987,p.29). Nocon(1994) neatly summarizes that 'the development of a mixed economy of care is to provide more choice for users, greater competition, improved quality and lower cost'(p.26). As already mentioned, the government's policy for community care in Korea emphasizes the development of a mixed economy of care with the government remaining in a minimum role of sustaining community care for elderly people, while expanding the role of the private and informal sectors in the hope of saving public money.

In addition to a mixed economy of care, the purchasers/ providers split is a key organizational element to care management. The split between purchasers and providers is for two distinct areas of work:(a) 'the assessment of individual's needs, the arrangement and purchase of services to meet them and (b) direct service provision' (Sheppard, 1995,p.8). This element is seen as central to promoting services that are both high quality and cost-effective (DHSS,1991; Lewis & Glennerster, 1996,p.74). According to the Social Service Inspectorate (1993) in its interim overview report on assessment and care management, a clear purchaser-

provider split aids the process of moving from a service-led to a needs-led approach(Lewis & Glennerster, 1996, p.75). The report of the Price Waterhouse/ Department of Health(1991) identifies three different approaches to developing a purchaser/provider split: 'functions at strategic level only(macro level); at senior management team level(micro); and/or at the local level'(Means & Smith,1994, p.127). As discussed in chapter 4, services in community care for elderly people in Korea still heavily depend on direct service provided by social workers. Some services are provided by the mechanism of contract between purchasers(the HWC) and providers, for instance home help services. The 'contract culture' is very new in community care in Korea. Under fully developed conditions of the purchasers/ providers split, care management may give benefits for greater choice for social workers and elderly clients in community care in Korea. A mixed economy of care and the purchasers/ providers split, regarded as the most important principles at system level to develop care management, should be operated through community care for elderly people in Korea.

*A needs-led approach*

Within the wider service system, care management is intended to mediate between the needs of individual elderly people and their carers and available community services. As mentioned earlier in definitions(see chapter 2), care management emphasises adapting services to need rather than fitting people into existing services. A number of inflexible and traditional services often did not meet their needs or were organized to meet the requirements of service providers

rather than service users and their carers. A needs-led approach could overcome these major weakness as in existing practice(Mean & Smith,1994, p.110). The needs-led approach is seen as having two key aspects: separating assessment from service provision by focusing on the client's needs and shifting influence on assessment from providers to purchasers (DoH,1990; Payne, 1995,p.72). As shown in the results of field study, needs assessment and care planning are the most frequent performed by tasks by social workers in the HWC. Clients' needs assessment is not clearly separated from service provisions, especially care planning in community care in Korea. Services tend to be provided by a routine/stereotyped response to clients' needs and traditional social work practice.

Need must be considered as a complicated concept which can be defined in a variety of ways for different situations(see chapter 2). There are no clear and detailed government indicators or statements of needs, especially elderly people's needs in Korea. A few academic works on elderly people's needs have recently been compiled by Korean researchers, for example Lee, KO.(1995) and Lee,KH.(1996). The indicators of elderly people's and carers' needs used in this research were constructed on the basis of the PSSRU work in the University of Kent in the UK. As discussed in the previous chapter, the amount and type of services that elderly people and their carers need from the HWC depends on their circumstances and abilities as well as the scope of personal networks. Sometimes rural elderly people's and carers' needs are the same those in urban, but sometimes they are different.

*Cost effectiveness*

The question of cost is basic to a broader analysis and understanding of care management in community care(Rothman, 1992,p.7). As sheppard(1995)argued, the common aim of care management is 'to produce a quality service as cost effectively as possible within an agreed timescale'(p.11). The key elements in achieving cost-effectiveness are 'an accurate assessment of the needs to be met and a system to ensure that resources are allocated to meet them'(Flyn & Dolen,1994,p.109). Practitioners are expected to establish user's wishes and the costs of the selected options of community care services. The care management process, therefore, requires costing of the care plan(ibid) and seems to be a more realistic approach as it balances need and resources, taking account of scarcity and choice. .

In Korea there is a constant concern about containing costs for services in community care, while maximizing the impact of service delivery within the constraints of scarce resources. With the use of a practical care management model, social workers can manage the overall plan of care and, if needed, authorize the purchase of services. This approach to practice is viewed as a means of containing costs while maximizing effective service delivery (Zawdaski, 1983; Roberts-DeGennaro,1993,p.110). Cost effectiveness is likely to be one of the most influential principles in developing a care management in Korea.

## Clients-level principles

*Participation*

The increasingly widespread view is that the switch to more user-centred community care for elderly people is likely to be achieved by making possible greater participation of elderly people who use community care(Open Univ.,1993;Lim, 1995,p.26). Clients' participation in the community care process is 'to provide users with a range of realizable opportunities to define their own needs and the sorts of services they require to meet them'(Walker,1993,p.223). It is 'a prerequisite that there should be a wide acceptance of elderly clients' rights to participation in the community care process and decisions and sometimes this should be incorporated into legislation and official guidance'(Payne, 1995,p.181).

In Korea there has not been a clear statement of the rights of elderly people in relation to the broad spread of community care. This concern is important because elderly people are regularly exposed to situations where professionals take decisions on their behalf. The services in community care for elderly people have tended to create a lifestyle for them. The background to service provision for elderly people in the community is one of limited options and restricted packages of services(see chapter four). Furthermore, community care services for elderly people rely heavily on the professional and the judgement of needs by the professional, for example social workers. This means that the services have been designed primarily by non-service users.

Thus, values and expectations about the benefits and appropriateness of services tend not to be developed by consulting elderly service recipients and their carers.
The segregation of elderly service-users and carers may well work against the principles of integration, participation and normalization. One possible answer is to include elderly service-users and/or carers in the design,planning, and management of community care in Korea. The movement towards user's participation is one of the evidences of the failure among professionals to consider the wishes of people being cared for and their carers(Payne, 1995,p.181). But, for professionals to allow clients participation in a community care process may be regarded as giving up some of their power, taking some risks, and stepping into hitherto unknown territory. Therefore, it is not easy for them to take this step lightly(Renshaw, 1987,p.5).
Although clients' participation in the community care process is encouraged, it would be a mistake to expect too much of this phenomenon for two reasons. First, 'it cannot be assumed that everyone wants to participate, and this raises the question of who participates' (Johnson,1990, p.162). It is not difficult to guess that frail elderly people could be excluded and their interests could be ignored. Secondly, 'it cannot be assumed that wider participation brings about wider and real power'(Johnson,1990, p.162). It is true that participation may give elderly clients greater power over their lives, but involvement at community level is not likely to lead to the exercise of real power without secure complaints procedures.

*Self-determination & choice*

According to Charnly(1987), freedom of choice has been one of the major influences on community care in recent years in the western countries(p.3). It reflects at least two fundamental concerns: first, 'the necessity of tailoring services to the clients' needs and preferences of consumers rather than providers; and secondly the corollary that the consumers' voice must, therefore, be sought out and heard'(Wistow, 1988,p.78). Self-determination and freedom to make wrong choices for elderly clients are on important individual right, so a dilemma faces the staff and care workers in balancing the acceptable and unacceptable choice of clients (Cambridge,1987; Lim, 1995,p.25). This has specific implications for the HWC where the increased provision of community care services for elderly people has been heralded by a growth in innovatory approaches towards caring for those living in the community. The rationale of community care for elderly people in Korea has to include the service users in centre stage. Self-determination, responsiveness to needs and the individualization of service provision should increasingly become central to the debate about community care for elderly people. For example, it needs to be explicitly stated that it is the needs of service users, not of services, agencies, authorities or professionals, which should guide policy and practice (Beresford & Trevillion, 1995,p.5). Such developments, Wistow(1988) argued, have tended to support the growth of consumerism(p.82). However, it is said that encouraging self-determination and choice depends on the relative dependency/independence and ability/disability of elderly

clients(PSSRU,1987a,p.7).

Many elderly clients may not be in the position to make optimal decisions alone or to freely exercise choice about care services. Physical and mental restrictions arising from disability 'associated with ageing combine with declining social resources to limit their access to knowledge and information which would enable them to make appropriate decisions'(PSSRU,1987a,p.7). Therefore, elderly clients in community care in Korea should have the opportunity to be empowered to consider alternative services, be aware of all existing services, and encouraged to exercise self-determination and choice.

*Empowerment & control*

The involvement of elderly clients in the community care process necessarily demands some degree of power and control. Traditionally, the power to make decisions and facilitate change for elderly people has been in the hands of care staff or service managers(PSSRU,1987a,p.6). One aspect of community care for elderly people has been an attempt to manage these people in the population, who are deemed by care staff to deviate from institutional norms(Open Univ,1993; Lim,1995, p.27). Norman Tutt pointed out that differences in power between professionals and service users could often lead to difficulties for client involvement because professionals sometimes have power and authority over clients(Open Univ,1993a;Lim,1995,p.27). A needs-led approach has entailed a progressive revision of organizational structure and procedures in community care. The rationale for the reorganization is to be focused on the clients'and carers'

power(DoH, 1991a,p.11).

The importance of empowerment is considered as crucial in making services responsive to the needs of elderly clients in community care in Korea. One way in which a needs-led is approach used for empowering clients is to help them live as independent a life as possible. A second element of empowering is preventing service users from being subordinate to the wishes of service providers(DoH, 1991a,p.9). Sometimes it is possible to gradually develop power and responsibility in user groups, as training and education helps them to develop the skills necessary to enable self-determination. The availability of information for service users is also crucial in their empowerment regarding service choice(DoH, 1994,p.9). To change the balance of power to reflect the views of elderly clients requires a radical rethink of service values and decision-making mechanisms in community care in Korea.

*Advocacy & risk-taking*

Advocacy and its partners, citizen-advocacy and self-advocacy have become common parlance in community care for elderly people. It is high on the practice agenda along with words like normalization and empowerment in community care (PSSRU, 1987a,p.10). Harris suggests there trends in service delivery which have prepared the ground for advocacy. 'First, the increasing complexity and fragmentation of service provision; secondly, the introduction of information technology; third, consumer dissatisfaction'(Renhaw, 1987b; Lim,1995,p.28). Advocacy is particularly important for the care of frail elderly people who are effectively unable to communicate in

community care in Korea.

Several of issues, as argued by Renshaw(1987), arise which continue to demand attention and debate. Defining the role of advocates can be particularly fraught with difficulty. Furthermore, as Dowson(1990) observes, there are some concerns about 'keeping it safe':

"The disadvantages are that the idea of advocacy starts with professionals and service-providers; that advocacy can become a delaying tactic and a talking shop; and the term itself is part of professional jargon which people involved in users group are trying to challenge"(Open Univ. 1993b; Lim,1995,p.28).

It would be helpful for a clear statement of how we can ensure that the power which social workers have can be challenged in circumstances where people can neither fully represent themselves or lack an advocate working on their behalf (Phillipson,1992,p.125). But the sponsoring body may be unwilling to give real authority to people needing their advocates in respect of making key decisions. There may be few inducements to organizations to take read account of the views of either the person needing support or their advocate. In addition to advocacy, risk-taking has always been of great concern to service delivery agencies in community care. The movement to community from family care represents a major life change for elderly clients(PSSRU,1987b,p.3). They will become vulnerable to a wide range of social risks. Elderly clients who are left alone in their home are bombarded by new risks which people leading ordinary lives may take for granted. There are also skills required for a normal life in the community (Cambrige,1987,p.2). For elderly people specific risks most frequently met are those related to physical dangers, eg. leaving gas on with the possibility of causing an explosion; falling, particularly where elderly

people live alone; physical abuse by a carer; and hypothermia. Despite widespread concern regarding the risks to which elderly people are subject, there is uncertainty about appropriate responses to risk situations. The absence of a set of normal expectations makes for 'greater difficulty in estimating the likelihood of being exposed to specific risks and leads to a correspondingly greater degree of uncertainty'(Charney,1987, p.14). This reflects uncertainty as a central element in risk, and leads to difficulty in offering clear guidelines for practice in community care for elderly people in Korea.

# CHAPTER VI

# CONCLUSION

## FINDINGS

The hypothesis for this study has been: 'it is feasible to introduce a form(s) of care management into the development of community care for elderly people in Korea'. It is time to highlight the findings of the research, to relate this to the original hypothesis. A clearer picture emerges to support the main hypothesis of the study. More precisely, the conclusions are confirmed as seen in the findings at macro, mezzanine, and micro level.

### The macro level

Korea meets the basic preconditions for introducing welfare provision modeled on western countries, especially the UK, because of a comparability of political economy affected by the influence of a global economy.

Korea's economic growth has been achieved through strong government market manipulation, which influenced the welfare sector to make resources available. It has been shown that welfare expenditure and services have considerably increased in Korea(see chapter one). However, due to the recent economic crisis, public debate has been suppressed on both the increasing welfare demands and the cost-effectiveness /efficiency of services. It is expected that the Korean

government will have reviewed welfare policy and have examined policies in western countries, including the UK, in order to improve cost-effectiveness and efficiency in the welfare sector. These may lead the Korean goverment to enforce the functional expenditure for welfare provisions(see implication of the neoliberalism in chapter three). As a result, policy makers hesitate to implement innovative schemes such as care management in community care for elderly people.

In aspects of political ideology and global influence, it has been shown that the Korean government has driven social policy to develop a mixed economy of social care, based on neoliberalism, to meet the needs of elderly people and their carers(see political contexts in chapter one and implication of the neoliberalism and globalization in chapter three). This finding suggests the high applicability of a western style welfare system, especially the UK, to Korean society. This is because its key elements reflect Korea's characteristics, while its major principles are also applicable to our social policy needs, especially community care policy for elderly people. This is not to say, of course, that the UK, which has a long tradition of neoliberalism, is the same as Korea. History suggests that the same ideology may give birth to different kinds of welfare structures(see chapter three). Korea needs to be understood in such a way to acknowledge that she can create her own social policy in ways which differ from that of the UK, but according to the same principles, eg. a mixed economy of care. It means that Korea can only use UK experience as a model. Korea has to seek its own solution to its own problems with considerable adaptation to local conditions.

## The mezzanine level(system)

As identified in chapter two and chapter three, the most important pre-conditions needed for the application of a form(s) of care management are a mixed economy of care, and correct use of the purchaser/provider separation. The findings have confirmed the importance of a system approach involving social workers' acting as providers or purchasers. The implications derived from three projects, representing different models of care management implemented in the UK, suggest the possible application of a UK model(s) for Korean. The multidisciplinary model(Darlington) could prove the most difficult to implement in the Health and Welfare Center, considering current Korean service resources and the service delivery system in community care(see chapter four). On the other hand, the social and health care model (Gateshead) has, as expected, proved to be associated with the most type to adopt in Korean society. There are three reasons for this: Firstly, the setting(the HWC) and the purpose of the project have proved to show the most similarity to the model. Secondly, the target population and the influence on them of the functioning of this model are also similar. Thirdly, the roles of social workers in Korea are generally similar to the care managers's roles in the model, especially in terms of social workers being required both to be purchasers and providers of services.

Other conditions indicating the feasibility of the model introduction into the HWC are (a) the high level of nurses' and social workers' education and experience; (b) potential access to welfare resources; (c) the presence of a strong

change-oriented policy. Much of the evidence from the study showed that there were crucial problems within the model to be observed (a)the two agencies(health and social care) are only slightly integrated ideologically; (b) the workers' low motivation for change and development; (c) the two services are passively integrated by policy action.
Whichever models are adopted, it is clear that an innovation that introduces of care management will involve a considerable change in the service delivery in community care as well as requiring social workers' roles changing to include that of a care manager. These issues require the person who is the best qualified professional to become the care manager, someone who is required to have a sophisticated understanding of the whole process of community care and care management in practice. However, care managers' roles are mainly required within an environment where the social work approach is pervasive. Therefore, social workers are regarded as the best professionals to be care managers in Korea(see strategies for the implementation of care management in chapter five).

## The micro level(clients)

The results confirm that one most important principle for introducing care management is a needs-based approach in line with 'consumerism'(see chapters two and five). There is some evidence that community care has failed to provide services with a needs-based approach for elderly people in Korea. The service delivery mechanism has been unsatisfactory in that there has been almost no attempt to devise differentiated strategies to meet the different needs of elderly clients(see

implications of needs in chapter two). Evidence for differences of needs in the majority categories between rural and urban elderly people, between the ECF and the ECC group, and between rural and urban carers does not emerge when assessing the statistical significance($p<0.05$) (see chapter four). The needs of elderly people, when dealing with mobility of the PADL and heavy domestic tasks of the IADL, are the most important ones requiring community care services. There is also evidence that the carers' significant needs depend both on elderly people's dependency levels and the services available(see chapter four). These results indicate that service development and a clinical approach should be part of the function of care management in Korea. On the otherhand, elderly people and their carers have a strong sense of stigma in relating to welfare services (chapter four). This finding suggests that there may be a rare possibility of being implemented a form of UK care management(see rationale for the research in chapter one). As a result, a partial and stepping-stone approach should be employed to develop a care management program. The natural caring services should be linked and developed in which the formal services should be enhanced/coordinated with the informal networks by a care management program(see chapter one and chapter five).

To summarize, although this study cannot, of course, resolve all issues about the feasibility of care management for Korea, it demonstrates what are surely the most fundamental issues in the applicability of a UK model(s) for Korean society. The study shows empirically what are the macro, mezzanine, and micro factors related to the feasibility of the UK care management for community care for elderly people

in Korea. It indicates how such a model(s) is likely to work, by generating a form of care management which is beneficial to elderly people. A well-known difficulty, of course, pertains to the limitations in making generalizations from the results of an academic study. It can only demonstrate the feasibility of the UK care management for introduction in Korea, but we lack precise knowledge about the effects of such a system, should it be operated on a nationwide scale.

## PROSPECTS

Forecasting is a difficult task, and one of which social scientists are normally very wary. The failure to predict the recent state of the Korean economy is the most chastening evidence for the capricious nature of policies and reveals the difficulties of prediction. With this caveat in mind, certain conjectures can be offered:

a) a higher proportion of elderly people and their carers will benefit and accept more from care management services, based on consumerism than from the traditional services

b) a care management approach will be more cost-effective and improve accountability than the traditional range of services.

c) social workers' roles when acting as care managers will emphasize indirect activities(purchasers) more than direct ones(providers).

d) care management services will respond to a combination of clients' needs with packages of care on the basis of a mixed economy of care. Care management will show a greater sensitivity to relationship needs, and make resources available.

e) allowing for scarce resources for community care, care management will be operated on a basis of accurate information of needs, services and costs.

f) rural model(s) of care management will differ from urban one(s).

It will take some time to develop and implement care management in community care in Korea. In particular, this is because the notion of 'eligibility' for care management is unfamiliar to both policy-makers and professionals. Therefore, careful research is needed to monitor whether and how care management will contribute towards seamless community care services. In the longer term, the development of a new service delivery mechanism in Korea will depend on the Government policy-related issue of the success of certain projects. The implementation of care management offered through clear policy statements will be more secure if, and when, promising results of projects become available for the development of care management.

# APPENDIX

## Appendix A

## Questionnaire for elderly people

I] Socio-demographic factors(Tick the item you are relevant)
Example: Sex;1)(V)Man, 2( )Women

1. Age( Year)

2. Sex
1)( )Man
2)( )Women

3. Marital status
1)( )Married
2)( )Single(not married)
3)( )Widow/divorced

4. Household composition
1)( )Living alone
2)( )Living with spouse(couple)
3)( )Living with spouse, eldest married son/draughter-in-law
4)( )Living with others relatives
5)( )Living with non-relatives

5. Tenure of dwelling
1)( )Owner occupier
2)( )Private rented(monthly)
3)( )Private rented(yearly)
4)( )Council rented
5) Others( )

II] Personal activities of daily living & Instrumental activities of daily living

[I] Personal activities of daily living

7a( )Washing self
7b( )Bathing
7c( )Dressing
7d( )Going outside
7e( )Get up from bed
7f( )Using toilet
7g( )Mobility in home

7h( )Managing toenails
7i( )Collecting/phoning

[II] Instrumental activities of daily living

8a( )Light housework
8b( )Making drinks/snack
8c( )Preparing meals
8d( )Heavy housework
8e( )Shopping
8f( )Laundry

III] Health problems

[I] Physical health

9a( )Eyesight
9b( )Hearing
9c( )Speech
9d( )Urinary incontinence
9e( )Faecal incontinence
9f( )Risk of falling
9g( )Breathlessness

[II] Mental health

10a( )Depressed mood
10b( )Loneliness
10c( )Confusion/disorientation
10d( )Memory loss
10e( )Comprehension

IV] Current service allocations and needs satisfaction

11a. Are you satisfied with formal care ?
1)( )Satisfied 2)( )So so 3( ) Not satisfied

11b. Are you satisfied with informal care ?
1)( )Satisfied 2)( )So so 3)( )Not satisfied

V] Attitude to welfare services receiving/to receive

12a. How do you think you are getting/to get services from agencies/other people ? 1)( )Positive 2)( )Negative

12b. If you are negative to get/getting services from agencies/other people, Why ?
1)( )No need 2)( )Burden on getting services 3)( )Family does not like 4)( )Damages reputation 5)( )Others( )

**Questionnaire for carers**

I] Characteristics of carers

1. Sex
1)( )Male
2)( )Female

2. Age( Year)

3. Marital status
1)( )Married
2)( )Single
3)( )Divorced/missing

4. Employment status
1)( )Employed
2)( )Unemployed

5.Relationship to elderly people
1)( )Spouse
2)( )Son/daughter-in-law
3)( )Daughter
4)( )Brother/Sister
5)( )Other relatives
6)( )Non-relatives

6. Do you have secondary helper(yes/no)
Number( )

7. If yes on question 6, what kinds of helps have you received?
1)( )Direct help
2)( )Financial help
3)( )Decision-making
4)( )Others( )

8. Number of hours per day on caring( )

II] Activities

10a( )Help with personal care

10b( )Physical help
10c( )Helps with paperwork & financial application
10d( )Other practical help
10e( )Keeping him/her company
10f( )Taking out
10g( )Medication
10h( )Keeping an eye on him/her to see
10i( )Others(  )

III] Consequences of care giving in carers' life

[I] Personal aspects

11a( )Physical health problem
11b( )Loss of sleep
11c( )Unable to relax
11d( )Feelings of depression
11e( )Life satisfaction
11f( )Used psychotropic medication
11g( )Others(  )

[II] Social aspects

12a( )Restriction on contact friends/family
12b( )Restriction on church/club attendance
12c( )Restriction on time spent in hobbies
12d( )Restriction on time spent relaxing
12e( )Others(  )

[III] Changes in family routine

13a( )Space
13b( )Family conflict
13c( )Sensitive communication between elderly people and family member
13d( )Others(  )

[IV] Financial aspects

14a( )Remodel house for elderly people
14b( )Spend money for supportive service
14c( )Stop working for the care of elderly people
14d( )Others(  )

IV] Needs for coping and caring skills

[I] Needs for coping

15a( )GPs

15b( )Visiting nurses
15c( )Day/overnight services
15d( )Day/overnight respite care
15e( )Home help service
15f( )Private care service
15g( )Nursing home
15h( )Secondary helpers
15i( )Voluntary service
15j( )Financial support
15k( )Carer support group
15l( )Counselling
15m( )Telephone hotline
15n( )Others(  )

[II] Needs for caring

16a( )Education video
16b( )Training workshop
16c( )Written material about caring
16d( )Behaviour management skill
16e( )Medication skill
16f( )Others(  )

V] Attitude to elderly people caring

17a. What is the reason why you are caring for elderly people?
1)( )Family relationship(sense of duty)
2)( )There is only me
3)( )I love him/her
4)( )Emotional rewards
5)( )Reciprocity
6)( )Religious motivation

17b How do you feel caring responsibility ?
1)( )Happy helping
1)( )Accept it
3)( )Can not seem to get through to him/her
4)( )Ties me down completely

**Questionaire for social workers**

I] Background information(Tick the item that apply)
Example: 2. Sex; 1)(V) Man, 2)( )Women

1. Age(  year)

2. Sex

1)( )Man
2)( )Women

3. Qualification
1)( )Social work
2)( )Nursing
3)( )Others(eg. Therapist)(  )

4. Employment career as social worker (  Year)

II] The tasks undertaken(Tick all tasks you undertake from 5a to 8c). Example: 5a;(V) Intake

[I] With clients

5a( )Intake
5b( )Assessment
5c( )Care planning
5d( )Monitoring
5e( )Check/Review visit
5f( )Coordinating resources
5g( )linking resources
5h( )Information/advice/counselling
5i( )Social skills education
5j( )Advocacy
5k( )Group work/activities
5l( )Going to bank/financial application
5m( )Others(  )

[II] With informal carers

6a( )Information exchange
6b( )Advocacy
6c( )Emotional support/counselling
6d( )Carers' needs assessment
6e( )Education/training for carers
6f( )Others(  )

[III] With formal networks

7a( )Information exchange
7b( )Negotiation over change in service
7c( )Others(  )

[IV] With informal networks

8a( )Develop new resources
8b( )Liaise/linking informal resources
8c( )Training/education volunteer
8d( )Others(  )

III] Available resources(Tick resources which is available in community care from 9a to 11i). Example: 10a(V)Group work.

[I] Community resources

9a( )Home help
9b( )Private paid help
9c( )Private paid nursing
9d( )Night sitter
9e( )Volunteer involvement(neighbour)
9f( )Meals-on-wheels
9g( )Laundry service
9h( )Occupational therapy
9i( )Transport
9j( )Material improvement
9k( )Lunch/social club
9l( )Hair cut
9m( )Others( )

[II] Residential resources

10a( )Group home
10b( )Sheltered housing(short & long-term)
10c( )Private nursing home
10d( )State-run(non-paid) nursing home
10e( )Day care
10f( )Others( )

[III] NHS resources

11a( )GPs
11b( )District/community nurse
11c( )Hospital
11d( )Others( )

IV] Other system factors

12a. What is the most useful sources of information in respects of client's referral ?
1)( )Client's phone/visiting, 2)( )Home visiting
3)( )Other agencies, 4)( )Informal sources

12b. Who is the most powerful player in decision-making for providing services( ) and how much do you influence to decision-making for providing services ?1)( )100%, 2)( )75%, 3)( )50%, 4)( ) 0%

## Appendix B

*Time table of field research in Korea*

7th - 12th, July, 1997----------

* Discussion about community care and care management with Prof. Mandu Kim, who was one of top senior professors in the academic society of social welfare in Korea, and translated Moxley's book, *Care management in practice*, into a Korean version.

* Popping in the National Assembly Library in order to do literature survey on elderly people, community care, care management, delivery system of social service, need of elderly people, some statistics, etc. in Korea.

* Translating questionnaires into Korea terms.

* Visiting the Health and Welfare Centre(Seoul) to arrange the interview schedule, and to get an orientation about the organisation.

* Group discussion about community care and care management at the Hanra general welfare centre(manager(1), social workers(3), social work students(2).

14th, July,1997----------

* Group discussion about community care and care management for elderly people at the Shinwool general welfare(manager(1) & social workers(5).

* Pilot interview with a social worker, an elderly people, and a carer. Questionnaires were revised.

15th - 17th, July, 1997----------

* Interviewing with urban elderly people(10), who were getting community care services from the Health and welfare Centre.

* Discussion about community care for elderly people with Prof. Jengsu Oh, who introduced the term 'community care' into the Korean academic society.

18th - 24th, July, 1997----------

* Visiting the district offices to get list of elderly people, who were carded by their family members/relatives. Interviewing with urban elderly people(10) and their carers(10).

* Meeting Dr. Sangyoung Lee, who was a manager of Dept. of Health and Welfare of Korean government to talk about government policy for welfare services.

* Meeting Prof. Kunhong Lee, who studied on care management on Korea in doctoral degree in 1996 and talked about the feasibility of care management in Korea.

25th - 27th, July, 1997----------

Visiting the Shlim welfare centre to observe a luncheon service for elderly people.

* Visiting the Saryangeujeep(an elderly people's Home) to talk about needs of elderly people.

* Group discussion with social workers(senior manager(1), team managers(2), and social workers(12)) of the Health and Welfare Centre(Seoul) and interviewing with them(10).

28th - 30th, July, 1997----------

* Visiting Nambu Noyn Bookji Hyeukwan(a general welfare centre for elderly people, where provided home help service, day care service, etc. for elderly people.

* Meeting Prof. Yanggon Kho, who was specialised in welfare services for elderly people.

* Visiting the Health and Welfare Centre(Hongchen, rural) to fix time for interview.

4th - 19th, Auguest, 1997----------

* Getting an orientation about the Health and Welfare Centre(Hongchen-Kun).

* Interviewing with rural elderly people(10), who were getting services from the Health and Welfare Centre.

* Interviewing with rural elderly people(10), who were cared by their family members/relatives and interviewing with rural carers(10).

* Group discussion with social workers(team manager(1) and social workers(10)) and interviewing them(10).

* Visiting elderly people's Home run by Catholic church.

20th - 25th, Auguest, 1997----------

* Data processing a computer

* Visiting the Social Science Library, the National Assembly Library, and Korean Institute for Health and Welfare Affairs, where produced the first year evaluation report of the Health and Welfare Centre Project. Discussion about the Project with a researcher, Ms. Hyeju Kang.

* Meeting Mr. Kingdong Cho, who was a president of association of community care for the aged in Korea and introduced home help service to Korean society for elderly people. Discussion about differences of community care between the UK and Korea.

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