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# **The Hybrid Status of Family Care Helpers in the Long-Term Care Insurance Scheme for the Elderly in South Korea**

*FIRST DRAFT*

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## Abstract

In recent decades, population ageing has become a significant issue in many countries. South Korea has also become an ageing society. Whereas the ageing rate of South Korea is not high compared with that of western society, the country is nevertheless ageing rapidly. For these reasons, the Long-Term Care Insurance (LTCI) scheme for the elderly was introduced in 2008. The new social insurance was planned and enforced by the government, as there were several issues regarding South Korean traditional care culture and welfare system. Firstly, elderly care was offered mainly at home before the introduction of the insurance, i.e. there was a social norm that children should take responsibility for their parents: the elderly wanted to stay at home with their children and avoid entering a nursing home. Secondly, because of the family-centred care culture in South Korea, the social infrastructure for elderly care was insufficient. Lastly, the government put an emphasis on cost containment since the contribution rates of the LTCI could not be imposed in South Korean welfare context.

Against this background, the government involved former family caregivers in the social insurance system, when they get a licence for a care helper and enter to a contract with the care agency. A family care helper (FCH), who is a licensed family caregiver, gets recognition for her or his caregiving for the elderly and is paid through the insurance scheme. However, the FCH's caregiving can only be compensated in the paid care market through a contract with a care agency. The situation seems that the FCHs enter the paid care market, but their status differs from that of other paid care workers in that the FCHs have limited care recognition time and incomplete social rights such as a pension and unemployment benefits.

In this paper, I focus on the confused situation regarding the status of the FCHs and examine their location between the paid labour market and the domestic arena. In terms of methodology, available documents were collected and analysed. The primary data consisted of public documents, such as the Act on Long-Term Care Insurance for the Elderly, its enforcement decree and ordinance and government reports and other relevant documents of the major policy actors regarding the status of the FCH both in the labour market and the domestic area.

The findings revealed that the FCHs could neither be limited to being wage workers or pure family members because of their complicated status regarding entitlement to the social insurance and the provision of their labour market participation. The understanding of the status of the FCHs helps to set out criteria for the legal and policy making by providing conceptual implications.

## Abbreviations

FCH	Family Care Helper
KIHASA	Korean Institute for Health and Social Affairs
LTC	Long-Term Care
LTCI	Long-Term Care Insurance (Korea)
MHW	Ministry of Health and Welfare (Korea)
NHI	National Health Insurance (Korea)
NHIS	National Health Insurance Service (Korea)

## 1. Introduction

Care for dependents in ageing societies has become one of the most important issues in Asian countries. Many societies in Asia have taken elderly care programmes in the context of the social care services for children and elder people. The LTCI scheme for the elderly was introduced in 2008. The new social insurance scheme was planned and enforced by the government, as there were several issues regarding South Korean traditional care culture and welfare system. Firstly, elderly care was offered mainly at home before the introduction of the insurance, i.e. there was a social norm that children should take responsibility for their parents because the elderly wanted to stay at home with their children and avoid entering a nursing home. Secondly, because of the family-centred care culture in South Korea, the social infrastructure for elderly care was insufficient. Lastly, the government put the emphasis on cost containment since the contribution rates of the LTCI could not be imposed in the South Korean welfare context.

The concept of the FCH was neither official nor pre-planned by the LTCI programme. Rather, the concept has been constructed in response to the unexpected and drastic increase in family caregivers who have obtained licences to work as care helpers and who want to be recognised and paid for their caregiving by the LTCI. Since introducing the LTCI, there have been constant changes in regulations on the recognition of family caregiving. However, there is no political agreement on the issue of payments for family caregiving.

Against this background, it is necessary to be clear on the criteria of the payments for the family carer to reach an agreement on the social care. It is therefore important to set out the status of the FCH, who is placed between the formal and informal area of care for the elderly.

Earlier studies on the LTCI and the family carer in Korea have mainly focused on the one side of the characteristic of carers, which means the carers should be sorted into formal or informal, paid or unpaid. Recently, there has been several studies which have focused on the two-sided or multi-faceted characteristics of the FCH in the LTCI in Korea (M-S. Lee 2012; Yang 2013), but most studies have not intensely and theoretically debated the features of the FCH.

This paper aims to investigate the status of the FCH by tracing changes in the regulations on family caregiving from the introduction to the present. In Section 2, I review the literature and arguments relating to care arrangement, social rights, as well as care culture and family care. In addition, I explain the context of the LTCI in South Korea. Section 3 includes an analytical framework. In Section 4, I trace the trajectories of the changes in the status of the FCHs. I

focus on the confused situation regarding the status of the FCHs and examine their position between the paid labour market and the domestic area. This is followed by a discussion of the implications for Asian countries in particular and family caregivers and welfare states in general.

## **2. Literature review and the context of the LTCI in Korea**

### **State of the art on care, caregivers and care arrangement**

Elderly care has become one of the most important subjects in welfare states. This is not only because of demographic changes like increasing life expectancies and low fertility, but also because of social changes like increasing female economic participation and changing norms towards caring for the elderly. Due to these changes, the point of view about elderly care should move from the domestic area to social issues which should find collective solutions (Ma 2011; Moen and DePasquale 2017). Daly and Lewis (2000) have suggested the concept of ‘social care’ to understand the multi-faceted characteristics of care in relation to the welfare state. The concept of social care has potential for an analytic framework for the welfare state because of three characteristics of care: labour, relationships, and expenses. In addition, they argue that the concept of ‘social care’ has tried to overcome three dichotomies: formal/informal, childcare/eldercare, and paid/unpaid. Since then, there have been many studies which have focused on social care as an analytic tool of welfare states.

With respect to cost-sharing, there are also studies on how to arrange cost for elderly care (Theobald 2012). The concept of care arrangement refers to the configuration of the sharing of care burdens within actors in society, such as the family, the market, non-governmental organisations, and the state. Regarding care arrangement, many scholars suggest models which can elaborate on care arrangements, such as care diamond (Razavi 2007), and finance-provide nexus (An and Peng 2015).

Politics and the state also play an important role in legalisation and amending policies on care arrangement. Estévez-Abe and Y.-S. Kim (2014) reported that Korea was known as having family-centred care arrangements, but in recent years, childcare has increased as the consequence of the political compromise between political parties and interest groups. An and Peng (2015) suggest three different provision-finance nexuses as an analytical framework for welfare states and care arrangements. They argue that welfare states may be divided into three

different nexuses according to their proportional shares of the provision-finance nexus: publicly financed and provided; publicly financed and privately provided; and privately financed and provided. According to which value is more focused on by welfare states, the compensation types for family caregiving can be categorised into two: valuing care through time such as leave provision, and valuing care through money such as an allowance (An 2017: 187). In this course, welfare states play a pivotal role in the configuration care system and arrangement by using legalisation and amendment based on a state's welfare vision and family values (Pfau-Effinger 2015: 327ff.).

Kremer (2007) has suggested the concept of rights to give care as compensation for caregiving such as tax, social security and leave. Besides these compensations, cash payments for care are one of way of compensating for family caregiving. While there have been many arguments and discussions regarding payments for the elderly care services in the western world, there have been fewer tendencies towards cash payments for elderly care in Asian countries. Seok (2006) noted that the government was not allowed cash for elderly care in the discussion of the introduction of public long-term care (LTC) system in South Korea since the government worried about payment abuses, and the cash for care could lead former informal caregivers, mainly women, to stay at home instead of entering the paid labour market. However, Y.-K. Lee (2011) reported that as the number of the FCHs had increased, the number of claims of cash payments<sup>1</sup> had decreased, which means that although the payments for FCHs differs from cash for family care, such as a care allowance or attendant allowance, the payments the FCHs received are likely to be perceived as cash payments. She asserted that there needed to be measures such as cash payments to respond to the needs of the recipients and the family caregivers. In contrast, Hong (2011) asserted that the government should remain committed to the principles of in-kind benefits in the LTCI, and the government should improve the quality of care by introducing a care management system.

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<sup>1</sup> In the LTCI in South Korea, the cash payment is very limited. The cash payments are allowed only in the case according to Article 24 of the LTCI for the elderly as follow:

Article 24 (Family Care Cash Benefits) (1) If any of the following beneficiaries has received long-term care benefits equivalent to home visit care under Article 23 (1) 1 (a) from a family member or another person, the NHIS may provide the beneficiary with family care cash benefits in accordance with guidelines prescribed by Presidential Decree:

1. A person who resides in an area determined and publicly notified by the Minister of Health and Welfare as an area in which long-term care institutions are significantly insufficient, such as an island or a remote area;

A person recognized by the Minister of Health and Welfare as one who has difficulty in using long-term benefits provided by long-term care institutions due to a natural disaster or any other reason similar thereto;

A person who needs to receive long term care from his/her family members, etc. due to his/her physical or mental conditions, character, etc.

(2) Procedures for reimbursement of family care cash benefits under paragraph (1) and other necessary matters shall be prescribed by Ordinance of the Ministry of Health and Welfare.

In the past, care could be obviously divided into two: unpaid informal care mainly offered by family members; and paid care offered by wage workers in the labour market. However, demographic and social changes have blurred the boundaries between formal and informal as well as paid and unpaid. Frericks et al. (2014) compared the family care policies of three European countries and argued that the level of the formalisation of care varied considerably, from semi-formal to formal, classified by family care regimes. M.-S. Lee (2013) also reported that FCHs in South Korea experienced confusion in boundaries between caring for family members as the job of FCHs who obtained a care helper licence and as a part of daily life which is related to family obligations and love.

These complicated characteristics of care has become one of main subjects of care policies. Kremer (2007) argues that it would hard to understand patterns of women's labour without observation through the care lens, and the citizenship should be reconstituted itself as rights to participate not only in the paid labour market but also in care outside of the paid labour market. In this, the status of caregiver is the entitlement to social rights based on the individual's status. However, the individual's status is not a single form; rather, it is constructed and overlaps in multiple layers. Hwang (2007) argued for the three-fold dimensions of women's social rights based on three different positions of women as wives, mothers, and workers, and there needed to be discussion of the 'responsibility mix' to maintain adequate women's rights in both public and private areas.

Engaging a FCH in South Korea is also understood as a response of family caregivers from the perspective of care culture. Pfau-Effinger (2005a) termed the concept of welfare culture in the sense of welfare states analysis, which means 'the relevant ideas in a given society surrounding the welfare state and the way it is embedded in society' (Pfau-Effinger 2005a:4). Specifically, although same welfare programmes are introduced, the effects and consequences vary according to the state's cultural context (Pfau-Effinger 2005a:7). In Asian countries, traditional care culture for the elderly was mainly based on filial piety in the sense of Confucianism so that the previous studies on elderly care had also been about the experiences of family carers as informal carers in domestic areas. During the introduction period of the LTCI, there were studies on how the LTCI would affect the family (Choi et al. 2011). However, as it was only a short time since the formalisation of elderly care had become universal in South Korea, there has been little research into the complicated and confused situation related to family caregivers after the introduction of the LTCI (Choi and Kim 2013;

M.-S. Lee 2013; Young 2013), but there are still fewer studies which focus on the trajectories of change in the status of the family caregivers in the LTCI.

### **FCHs in the LTCI**

A FCH refers to a licensed family caregiver who obtains a care licence for the LTCI and takes care of the frail elderly at home. Some of them get the licence to take care of them; others get the licence before their family member gets ill.

Why has the government decided to include the FCHs in the formal insurance system? There are three reasons. First of all, one of the motives of the introduction of the LTCI was to reduce the elderly health care costs of the National Health Insurance (NHI). The National Health Insurance Service (NHIS) estimated that the proportion of elderly care costs will rapidly increase, from 8.2% in 1990 to 29.9% in 2008 of total health cost (NHIS 2009). Therefore, a new measure to deal with the elderly healthcare cost was needed. Historically, Korean social welfare expenditure has been low compared to other OECD countries. For example, the Korean government spent only 10.1% of GDP on social welfare expenditure in 2012, as compared to the mean among OECD countries of 22.1% of GDP in 2011 (OECD 2015).

The Korean traditional care culture has also affected the formation of the new LTCI system. Until the 1990s, LTC services in Korea were very limited. Until the introduction of the Welfare of the Aged Act in 1981, elderly care services were only fragmentarily offered to the elderly in poverty according to the Protection of Minimum Living Standards Act. In this period, there was no difference between the healthy and those who were in need of care. In 1981, elderly care facilities came into being according to the Welfare of the Aged Act, and the function of facilities have been divided into three: ordinary nursing homes, specialised nursing homes and specialised hospitals for the elderly.

Because of the culture of caring for the elderly, there was little infrastructure for care provision in both public and private areas (Peng 2011: 905). Before the introduction of the LTCI, most elderly care was offered by family members, especially by daughters-in-law. Elderly care services in public and paid market were very limited in Korea. Only the elderly on low incomes were eligible for public LTC services. The government has eased restrictions on manpower requirement criteria and equipment standards of LTC provision for fear of 'imaginary criticism' for a deficiency in the care supply (Seok 2010: 39). As mentioned above, before the introduction of the LTCI, care infrastructure had not been established, so that the

government tried to encourage providers in the private sector to enter the new paid care market.

In addition, the government considered the elderly care sector as a new growth engine. According to the Ministry of Health and Welfare (MHW) (2005), the new insurance achieved about 2,000 new jobs in 2007, and about 4,000 annually afterward. Because of the job creation effect, the insurance was supported by other ministries, such as the Ministry of Planning and Budget, even though the insurance would impose a financial burden (Park 2008:55). Therefore, the government tried to entice private providers into care industries. Several scholars have criticised the government's attempts on the grounds that they have led to a negative impact on the service delivery system and the working conditions of care workers.

### **Service delivery of the LTCI**

This section explores where the FCHs are situated in the LTCI by investigating the service provision system. The concept of social welfare service delivery refers to a structural series of connected processes among a service producer, a provider, and a user (Gate 1980; Kim 2007). Subjects who are involved in the insurance can be categorised into three groups: insurers, users, and providers. The LTCI is a form of social insurance which has a centralised fund system, and LTC services are produced by a provider and transferred to users. As an insurer, the NHIS regulated by the LTCI law carries out an examination of qualifications of entitlement, assessment and collection of contributions, grading of applicants, remuneration management, financing, and research. The user is also one part of the service delivery. A provider refers to not only producers of the service but also those who arrange and organise the service.

The FCHs are in both positions as users and providers. One of the purposes of the programme is to mitigate the care burdens of family members so that the FCHs can be considered as users even though the LTC service is directly offered to the elderly. At the same time, they are service providers who obtain a care licence for recognition as paid caregivers by the LTCI and make a contract with a care agency. With the contract, they are under the supervision of the public insurance system.

This section explores three aspects of the service delivery, including financing of the LTCI, access to the service, and the LTC provision. Firstly, I explain how the insurer finances the

LTCI. Then I describe how the user accesses the insurance, e.g. application, grading system, and the choice of service provider. Last, it is shown how the FCHs as providers are situated in the LTCI.

### **Financing: social insurance programme**

In general, financing of public LTC provision can be categorised into two types: tax-based and social insurance-based. The financing methods are likely to be influenced by former existing welfare institutions in a certain country. Scandinavian countries adopt a tax-based system to deal with LTC health costs, while continental European countries are likely to choose a social insurance approach to LTC financing. Korea adopted the social insurance scheme to the public LTC provision.

As a social insurance, the LTCI has universal characteristics in that the entitlement of the LTC services is required as an assessment of the need of LTC instead of the means test. The LTCI also has aspects of intergenerational contract in that the economically active population pays contributions for the elderly who do not participate in the labour market (Jegal 2009: 217).

The LTCI is financed by contributions which are regulated by presidential decree through the LTC committee. The contribution rate is determined according to the NHI rate and was imposed at 6.55% of the NHI contribution rate in 2016. In the case of the employee insured, both the employers and employees are equally paying their contributions, while the self-employed are responsible for 100% of the contributions. The employees insured, such as civil servants and state school teachers, as well as state, local governments, and private schools, are to co-pay 50% each, and in the case of private schools, the school pays 30% and the state 20%.

In addition to the contributions, state and local government share the responsibility for financing according to Article 58 of the Act on LTCI for the elderly. The state provides 20% of the expected annual revenue from LTCI contributions to the NHIS. The state and the local government are responsible for the payment of all management costs and the NHIS pays its share of the cost of issuing visit nursing orders, doctor's referral slips and LTC services for recipients of medical care assistance according to regulations by presidential decree.

As mentioned above, the Korean insurance system has characteristics that are low contribution and low benefit. Mitigating elderly care costs constraints was one of the primary

purposes of the LTCI so that the state sets the insurance as the low contribution and low services. In this circumstance, the inclusion of former informal caregivers was necessary to contain care costs (Im et al. 2011; Kim 2013)

### **Access to the service: the user's perspective**

To be a beneficiary of the LTCI, one has to meet several requirements. Although all those insured under the NHI are eligible for the LTCI and pay the contributions, the beneficiaries of the LTCI can only be the elderly aged 65 and older or those under 65 with geriatric diseases. To use the LTC services, they are required to go through the processes of applying, grading, and making a contract with a provider. To apply for assessment, the elderly in need of LTC should prepare documents, including an application for LTC assessment, and a doctor's referral slip (medical certification), and send documents or visit the NHIS in person. Then, the LTC Needs Certification Committee evaluates the status of the applicant's physical and emotional health according to their daily living activities. A trained examiner of the NHIS visits the applicant and evaluates the physical and intellectual functions, behavioural changes, nursing and medicine taken, and the needs of rehabilitation of the applicant based on an evaluation table researched by LTC experts. When it deems the applicant has difficulty taking care of daily life alone for over six months, based on the result of the assessment, the applicant is entitled to be a recipient of the LTCI.

The recipient can select services regarding types of care provisions as well as service providers in both public and private sectors. The LTC benefits can be divided into services and in-kind as well as cash benefits. Services are mainly supposed to be provided in the LTCI, while cash benefits are limited and are governed by strict preconditions so that they are rarely used in Korea.

The services can be categorised as in-home care and facility care according to the location of care provision. In-home care comprises home-visit care, home-visit bathing, home-visit nursing, day and night care, short-term care, and a provision of welfare equipment. The recipient can also select care facility services which help maintain and improve the elderly person's physical and mental health for an extended period in an LTC facility, except for hospitals specialising in the treatment of the elderly.

By using the LTC services, the recipients of the LTCI share a partial payment which is called an individual co-payment, the rate for which for in-home care services and facility care

services are 15% and 20% of the total costs they use, respectively. These payments are not charged to recipients defined by the Act on Guaranteeing People's Basic Life (public assistance). The 50% reduction to the co-payments is applied to those with income and assets under a certain amount set and notified by the Minister of Health and Welfare.

### **FCH as a service provider**

To be a FCH, an informal caregiver follows the same procedure of non-familial care helpers in the LTCI. One becomes a carer helper by taking an exam and obtaining a licence, and also by making a contract with a care agency; the FCH remains under the supervision of the agency to be paid by the LTCI.

To get a licence for a care helper in the LTCI, one should complete a course of study and pass the exam for the licence. The courses are regulated by the Act of LTCI for the elderly, and they consist of theory and practical techniques of LTC as well as a field placement. Each course requires 80 education hours and the trainee should attend more than 80% of total education hours in each area to take the exam. The education institutes therefore have a key position in the service delivery, especially manpower training system. The government opened the education system to market forces and increased the role of a private institute in the care system (Jegal 2009).

After getting the licence, the FCH makes a contract with a care centre. The care centre is an agency which arranges the LTCI's three subjects: the insurer (NHIS), the user, and the care helper. The centre makes contracts with both sides of service provision: a provision contract with the user who is entitled to care service of the LTCI and a working contract with the care helpers as a care worker. The types and hours of care services are specified in the contract, and the centre assigns a care helper to the recipient according to the contract. The working contract between the centre and the care helper regulates the working conditions, and the centre manages the working schedules of the helpers and gives the report on their caregiving to the NHIS for the calculation of monthly payments.

FCHs giving care to their family members seem to represent an informal relationship between the carer and those cared for. The government, however, divides them into two and puts them in the paid care market, i.e. the elderly and the informal caregiver should separately proceed to access to the LTCI services; the elderly should be entitled to the LTC service, and the FCH should obtain the licence for a care helper.

### **3. Analytic framework**

To trace the trajectory of changes in the status of the FCH, this study aims to investigate the government legislation and amendments of the LTCI. The following represents three dimensions as an analytic framework which covers the dynamics of elderly care arrangements among family, market, and the state:

- 1) How do the legislation and amendments of the LTCI define the scope of a family member's responsibility for a recipient of the LTCI? The scope establishes who is primary or partially responsible for the frail elderly person.
- 2) At what level can the FCH be formally recognised by the LTCI compared to payments of non-familial care helpers? Since the introduction of the LTCI, the payments for in-home care services offered by the FCH, and the level of time recognition has changed according to the notifications of the MHW. The level represents how the care responsibility is shared between family and state.
- 3) Concerning entering the paid labour market, how is the FCH controlled and regulated by the state? The regulation represents the status of the FCH who is located between paid and unpaid area of elderly care.

### **4. The trajectory of changes in payments for in-home care service offered by a FCH**

Although there have been several minor reformations of payments for in-home care services provided by FCHs, the most important amendment that had an impact on the status of a FCH was the notification No. 2011-72 of the MHW on 29 June 2011. In this section, I divide the period I analyse into two, before and after the enforcement of the amendment of notification No. 2011-72 of the MHW.

#### **Initial regulations on payments for family caregiving**

An initial regulation on payments for family caregiving was rough, and definition of a family member who is primarily responsible for the frail elderly person differed from the present one. Once one had obtained a licence for a care helper and made a contract with a care agency, she or he offered in-home care services to the recipients of the LTCI regardless of family relations between caregiver and care receiver. However, there were some differences in the level of

time recognition of their caregiving according to the family relations and their living arrangements. According to the notification No. 2008-66 of the MHW, when the FCH cohabitated with a recipient of the LTCI, payments for in-home care services offered by the cohabitated FCH were recognised only up to 120 minutes per day, while the services offered by a non-familial care helper were recognised up to 240 per day. The reduced payments, however, were applied according to the living arrangements whether the FCH and the recipient lived together or not; in other words, the FCH who lived separately from the recipient could be paid for their caregiving for the elderly up to 240 minutes per day. At the time of the introduction of the LTCI, even though the government presumed that the family should take primary responsibility for care for their elderly in the context of the principle of subsidiarity the concept of obliged family member was limited only to the cohabited family member according to Civil Code Article 779.<sup>2</sup>

In the initial period of the LTCI, the living arrangements of caregiver and receiver were the main criterion since the government assumed that some of the services the LTCI provided consisted of not only physical support for the elderly but also domestic work, which was hard to separate for the elderly from the whole household like dish-washing, laundry, and cleaning the house, so that the family member of the recipient should take responsibility for these household chores.

This tendency showed that the government tried to involve former informal family carers in the LTCI programme since the infrastructure and workforce in the social service were so limited at that time due to Korean traditional care culture being based on Confucianism. When the family carers were excluded from the LTCI, it could hinder the development of the infrastructure in the elderly care service market. Moreover, the Roh Mu-Hyun administration considered the social care service sector as one of new economic growth engines in an ageing society so that the administration mainly focused on expanding the elderly care market and providing employment. This attempt of the administration was bound up with the interests of agents in the care market place, including care education centres and in-home care agencies. Most of the care education centres and care agencies were established for profit and small and

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<sup>2</sup> Article 779 (Scope of Family Members) (1) Family members shall consist of the following persons:

1. The spouse, lineal blood relatives, and brothers and sisters;
2. Spouses of the lineal blood relatives, lineal blood relatives of the spouse, and brothers and sisters of the spouse.

(2) In the case of paragraph (1) 2, it shall be limited to the case where they share living accommodations.

individual business so that it was critical for them to secure attendees and recipients of the LTCI as customers to reach the break-even point.

Besides, the Korean traditional care culture also made possible to accept the limited payments for the cohabited FCHs smoothly. Elderly care has been considered the filial piety of the oldest son, while the wife of the son did the practical care labour in reality. As Korean society has industrialised, the adult children have been less likely to cohabit with their parents as in the agricultural era, but the private transfer in the context of an intergenerational contract lingered compared to other industrialised countries (Peng 2011). Therefore, the adult children consider their caregiving for their parents as reciprocal behaviour, and even the limited payments were for them considered better than nothing.

Indeed, there has been a drastic increase in the number of FCHs since the introduction of the programme than the LTCI had expected. KIHASA (2010) reported that former informal caregivers were likely to become a FCH instead, receiving the cash payments for family caregiving since the requirements of the cash payments were very strict and limited. The number of the recipients who received care payments for family care steadily decreased, from 1,004 persons in 2009 June to 763 in 2010 June. In contrast, the number of the recipients received in-home care services by the cohabited FCH has continually increased, from 2,689 persons in December 2008 to 39,966 persons in June 2010, which accounted for 26.3 percent of the total recipients who received in-home care services of the LTCI (KIHASA 2010). As the number of the recipients who receive the services by FCH had increased, the amounts of the payments for the services had also increased, from 1.2 percent in August 2008 to 22.4% in June 2010 (KIHASA 2010).

In these regards, the LTIC more severely restricted the scope of the responsible family member of the recipients and the level of compensation. Firstly, there came into force stricter regulations on the scope of the primarily obliged family member of the recipient. According to the notification No. 2009-125 of the MHW of 30 June 2009, a definition of the cohabitation had extended from living in one house to living in the same building, which meant the responsibilities for elderly care partly moved from state to family.

Secondly, the level of the compensation for the family care decreased. The recognition hours for in-home care services offered by the cohabited FCH had decreased from 120 minutes per day to 90 minutes per day, and when a recipient who receives in-home care services from the FCH, the recipient was not allowed to use additional in-home care services on the same day.

Also, the regulation noticed that the compensation for in-home care service offered by the cohabited FCH covered only physical supports for the recipients.

These attempts of the administration can be understood as a response to the radical increase in the FCH's caregiving (Y.-K. Lee 2010: 99). Although the administration considered how family caregiving should be arranged in the new social LTCI programme, the issue on family caregiving was only considered in the context of the financial constraints and the growth of social service industries as a social investment.

Despite the strict regulations of the administration, the FCH's caregiving had constantly increased. NHIS (2012) reported that the number of the claims for in-home care service offered by a cohabited FCH increased from 16,509 (16 percent of the total claims) in September 2009 to 32,015 in March 2010 (NHIS 2012 in N.-J. Yang 2013).

### **Reformation on the payment for FCHs in 2011**

Between June 2008 and June 2010, the regulation on the payments for the family caregiving has moved partly into the family's responsibility. However, there was no critical regulation on the status of the FCH until 2011.

In June 2011, the administration announced a notification about the amendment of the compensations for in-home care services offered by a FCH. The notification No. 2011-72 of the MHW contained three important amendments regarding the payments for family caregiving and the status of the FCH.

Firstly, the scope of a family member who has the primary care responsibility for the elderly has changed. The previous concept of the family member who had the primary care responsibility for the recipient of the LTCI was cohabited family members according to Civil Code Article 779, so that the cohabited FCHs were recognised reduced time (90 minutes per day) for their in-home care services for their family member who was entitled to the LTCI. However, the scope of the family member who had the primary care responsibility for the recipient has extended to all the family member. Regardless of the living arrangements, all the family member according to Civil Code Article 779 regardless of living arrangements have the primary care responsibility for their family member. Because of this regulation, there was no need for the division into FCHs according to living arrangements.

Secondly, the notification regulated the level of the payments. Regardless of the living arrangements, the recognition hours for in-home care services for the FCH has decreased from 90 minutes per day to 60 minutes per day and only 20 days per month. However, the administration contained an unusual clause for those who are over 65 years old and a spouse of a recipient of the LTCI.

Lastly, in addition to reductions of recognition hours, working conditions and social rights to pensions and health insurance are restricted since they are in family relations with the recipients, so that it could be considered as untypical status in the LTCI system. The care centre does not have to ensure working conditions for the care helpers such as severance money, employer's share of contributions to the National Pension System and the NHI, as well as the public unemployment insurance programme and occupational accidents compensation.

Although the FCHs obtains the license with the same procedure as non-familial care helpers, they cannot claim the same recognition for their caregiving. At the beginning of the LTCI in 2008, the government cut the recognition hours of the FCH cohabiting with the recipient in the sense of Article 779 of the Civil Code of the Republic of Korea. According to the announcement of the MHW (2008), the cohabiting FCH can be recognised for a maximum of 120 minutes per day instead of 240 minutes for non-familial care helpers. However, the FCHs, who reside separately from the elderly, could be recognised the same as the non-familial care helpers, at 240 minutes per day. The tendency of the restrictions on caregiving by the FCHs have been reinforced by two dimensions in the sense of family obligations. The care recognition time has been decreased from 120 to 90 minutes per day for the FCHs, who are the elderly person's spouses of more than 65 years old and to 60 minutes and only 20 days per month for the rest of the FCHs. Also, the scope of FCHs with reduced time recognitions has extended to all family members regardless of residence arrangements (MHW 2009; 2011). From this measure of the government, it is evident that the state considers the family's initial responsibilities for other family members, as Peng (2011) has pointed out.

## **5. Discussion**

As mentioned in previous sections, the FCH programme can be seen as a policy failure in that the administration considers less the characteristics of the family caregiving. The elderly care programme in Korea aimed to socialise elderly care as a social risk at first. The

responsibilities for the eldercare, however, has moved from the state towards the family. To trace the trajectory of the change in the payments for the FCH, it is evident that the status of the FCH is hybrid, beyond boundaries of formal and informal, as well as paid and unpaid labour.

The findings revealed that the FCHs could neither be limited as wage workers or pure family member because of their complicated status regarding the entitlement to social insurances and the provision of their labour market participation. The understanding of the status of the FCHs helps to set out criteria for the legal and policy making by giving conceptual implications. These changes also have implications for other Asian countries where should solve the problem of constructing of the public elderly care in the situation that the traditional care still lingers, and the state wants to ease the financial burden of the elderly care at the same time.

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