

# Long-term Care Hospitals

## and Changing Elderly Care in South Korea

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### Abstract

Until recently in South Korea, the central dilemma facing children with ageing parents was how and by whom their parents should be cared for. In accordance with the norm of filial piety, the eldest son used to take responsibility. However, with the recent proliferation of long-term care hospitals, this arrangement is changing. These institutions, which play the combined role of rehabilitative hospital, long-term care centre, and nursing home, admit elderly people who do not require active medical intervention. The government's promotion of these hospitals, centred on deregulation, ambiguity around their function, and the lack of alternative care facilities, has led to an expansion of the sector and consequently to the 'nursing hom(e)fication' of many of these institutions. While these hospitals ease the pressures associated with an ageing population, their mainstreaming has had an impact on healthcare, medicine, and the lives of elderly people. The hospital field has become commercialised, medical practice is being transformed, and the dignity of elderly people is being lost through hospitalisation. In this new care regime, filial piety itself is undergoing transformation—from an ideology underpinning the domestication of care, to the market idiom of service compliance. In this article, I introduce these hospitals and investigate how their growth has brought about a Korean style of elderly care commodification, revealing the undercurrents of healthcare privatisation and the neoliberalisation of welfare.

### Keywords

Long-term care hospital; Elderly care; Filial piety; Population ageing; Commodification of care.

## Introduction

Population ageing is a global phenomenon, as is the commodification of elderly care attendant upon it (Buch 2015; Aulenbacher et al. 2018). In relation to the trajectories leading to care commodification, however, differences exist among countries: in advanced economies where the welfare state is well established, commodification followed neoliberal reforms marked by privatisation, decentralisation, and the retrenchment of the welfare state (McGregor 2001; Da Roit and de Klerk 2014); conversely, in societies where welfare provision for elderly people is not fully established, commodification emerged as a surrogate measure aimed at unburdening the state of its welfare responsibilities while allowing adult children to continue to work and contribute to the country's economic development (Coe 2017; Leung, Lam, and Liang 2020).

With its welfare system a little over two decades old, South Korea belongs to the latter group despite exhibiting some elements of the former. In 2008, amid rapid population ageing, the government introduced long-term care insurance. Its implementation mostly followed neoliberal lines, with its strict eligibility criteria and market-oriented service provision (Yang 2017, 42–3). Typologically, the Korean regime probably sits between Germany and Italy, with a German-style reliance on social insurance for its financing and Italian-style market-based provision of care (Theobald and Luppi 2018), albeit without the latter's exclusive reliance on cash benefits and emphasis on the family as the locus of responsibility for care.

The story of Korean elderly care is, however, somewhat complex. A hidden sector exists that is taking on this role and which in doing so is contributing to the emergence of a Korean style of care commodification and the neoliberalisation of welfare. This sector consists of hospitals for the elderly. Because care in these hospitals is provided under the guise and within the infrastructures of medicine, such as the national health insurance (hereafter NHI) system, their services are registered as 'medical care'. The statistics speak for themselves. According to the OECD, as of 2014 Korea boasted the highest number of *per capita* elderly hospital beds, at 27 per 1,000 people (MOHW 2014, 7). This reflects a meteoric rise from approximately 4.5 in 2005 and is more than double that of second-place Japan with 11 per 1,000 (Choi 2014).<sup>1</sup>

So, how can we explain this rise in bed numbers in the absence of any corresponding breakthroughs in Korean geriatrics? The main reason is the government's creation of an entity called the 'long-term care hospital' (hereafter LCH) and its decision to promote these institutions by deregulating criteria around

1 According to Son (2012), the number of elderly hospital beds in 2005 was 25,042. Holding the changes in population during the period constant, this number translates to 4.5 per 1,000.

patient admissions, staffing, and hospital ownership. The implementation of a new NHI remuneration scheme for LCHs in 2008 additionally brought financial stability to these institutions. As a consequence, the LCH sector, in which considerable resources are spent on providing 'care', now accounts for more than 40% of the nation's hospital-level facilities.

The objective of this research article is to introduce this new type of hospital in South Korea, which simultaneously takes on the roles of rehabilitative hospital, long-term care centre, and nursing home, with an emphasis on caregiving. It discusses the implications of their explosive growth for the organisation of healthcare and medicine, as well as for the welfare of the elderly. The article begins by exploring the political economy behind the growth of LCHs. Specifically, it describes how, over the course of the International Monetary Fund-assisted recovery from the 1997 currency crisis that swept across the Asian countries, an economic ideology that prizes the market has made inroads into the country, influencing the state's healthcare policies. This investigation reveals that the small welfare state established following the crisis was underequipped to meet the challenge of population ageing. As a way of dealing with this problem, the state promoted LCHs. The result is an entity that straddles the realms of medical and social care and flouts the biomedical institutional division of labour between physician-led acute hospitals and nurse-led care homes (Abel-Smith 1964).

Next, the implications of the expansion of LCHs are considered. Beginning with the effects on how healthcare is organised, the article explains how LCH mainstreaming has led to the considerable commercialisation of the non-profit hospital sector, with the influx of non-medical actors following the *de facto* semi-privatisation of LCH ownership. The ability of these profit-seeking actors to own LCHs was made possible through the establishment of medical foundations, which can operate hospitals for charitable purposes in needy areas. Their influx has since contributed to the exponential growth of the LCH sector and, among other things, to the expansion of the medical job market. My investigation reveals that because of LCHs' focus on care, their commercial intent, and the competition for patients, admissions of those who do not need active medical intervention—or of what the government calls 'social admissions'—have increased. This has led to the nursing hom(e)fication of LCHs, i.e., the rendering of LCHs more like nursing homes, and concerns about the privatisation of healthcare. In addition, expectations around the roles of the medical staff working in these institutions have changed. This has resulted in adjustments to how medicine is practised, most notably by doctors, whose authority is compromised as the voices of nurses grow louder. This finding corroborates the thesis put forward by Claire Wendland (2010), following her study of biomedicine in Malawi, that the practice of biomedicine and its social relations manifest differently according to the local conditions under which they function.

The most significant implication of this situation, however, is for the elderly people admitted to LCHs and how their lives are affected by this new care regime. For many, the LCHs have become a place of living and death while being subject to medical control. As a consequence, cases bordering on neglect of the elderly are being witnessed. As LCH staff become surrogate caregivers, so the notion of filial piety, which has traditionally underpinned the moral economy of parental care, is also being reconfigured. Nevertheless, its core elements, namely the duty of children to repay parental sacrifice and to honour the wishes of parents to be with their children, remain the same.

The article concludes by summarising its contributions to knowledge in this area. These include elucidating how, through the ‘nursing hom(e)fication’ of LCHs, a Korean model of elderly care commodification that involves redefining the role of the hospital has emerged; furthermore, it demonstrates how this can be viewed as revealing the undercurrents of healthcare privatisation and the neoliberalisation of welfare. Clarifying the role of LCHs is important, primarily because they perform roles that are not officially admitted, i.e., caregiving roles contravene their ‘hospital’ status. Based on long-term fieldwork, an ethnography of these roles and their effects on the organisation of healthcare and medicine, as well as on the moral economy of parental care, is also presented. Reminding us of Robert Alford’s (1976) argument that the weakest interests in healthcare are repressed in a market society, the article ends by arguing that the dignity of elderly people is being lost in hospitalisation through the LCH care regime in order to serve the interests of the state, medical professionals, profit-seeking actors, and the adult children of patients, and that there is an urgent need to restore it.

Empirical data were obtained from fieldwork conducted in three LCHs between August 2016 and August 2019, during which time I was working as a doctor of Korean medicine (KMD)—a category of physician unique to the Korean healthcare system—practising traditional East-Asian medicine within a largely biomedicine-based regulatory framework (Na 2012, 2021). One particular LCH features centrally in the third section of the article.<sup>2</sup>

2 Ethics approval for this research was obtained from the head of the administration in Hospital K. My role as a physician-researcher embedded in the LCH raised particular ethical considerations. I was a physician, with legal, professional, and ethical duties to my patients, employer, and colleagues, so upholding these duties was the most important priority; my research interests were always secondary. I did not interfere in the lives of those who crossed my path, never questioned the conduct of others not directly related to my clinical work, and simply kept a daily journal. To protect the identities of the persons and institutions described in the paper, I have refrained from including any personally identifying information.

## **Population ageing, the ‘small’ welfare state, and the emergence of the long-term care hospital**

As in other countries in East Asia, in South Korea the population is ageing fast, due mainly to increasing life expectancy and decreasing birth rates (Goodman and Harper 2008). In 2018, Korean women were expected to live to 86 years of age, men to 78 years, while the average number of babies expected to be born per woman aged 15 to 49 was calculated as 0.98 (Statistics Korea n.d.). If this trend continues, by 2060 around 40% of the Korean population will be aged over 65 (Yang 2020, 300). The implications of such fast-paced ageing are apparent to Korean policymakers, who have observed Japan grappling with a stagnating economy and snowballing debt that can largely be attributed to health and welfare spending as a result of population ageing (Ikegami 2010, 97, 102; Yang 2020, 281). Having experienced the nation defaulting on its debt during the Asian economic crisis of the late 1990s, the Korean government is on double alert. Furthermore, the welfare regime introduced at that time—to cushion the impact of massive lay-offs incurred by the industrial restructuring recommended by the International Monetary Fund—has now grown into the form, though small, of a welfare state that provides a national pension, universal healthcare insurance, and unemployment and industrial accident insurance (Yang 2020, 76–94).

In the realm of welfare assistance for the elderly, a traditional at-risk group, the state took a further step in 2008. Following Japan’s lead a decade earlier, the Korean government enacted a long-term care insurance law under which elderly people with impairments that restrict their daily activities are eligible for support, either through home visits and daycare centres or through residential facilities called long-term care centres (hereafter LCCs) (Chon 2014, 707–10). Before then, scant facilities existed. In 2000, there were only 229 elderly welfare institutions, including public and private residential homes, in a country of 50 million (Prendergast 2005, 27). By 2011 there were still only 397 residential facilities, while those aged over 65 who lived alone, i.e., potential service users, numbered one million (Lee and Park 2012, 394–95). Although the the LCCs are being upgraded, alongside home visit and day care services these mostly private institutions can be managed by practically anyone and are under-equipped service-wise. According to a survey in 2015, half of the 3,823 LCCs surveyed were graded ‘poor’ for service (Lee 2015); well-resourced, public LCCs are few and have long waiting lists (Park and Kwak 2019, 244). Moreover, because of the limited medical resources available in these institutions, LCC residents have to travel to other clinics for treatments, thereby incurring additional costs.

To make matters worse, among those aged 65 and older the relative poverty rate—or the percentage of people with incomes of lower than 50% of the median

household income—is high: in 2015, it stood at 49.6%, while that of the general population was 14.6% (Hwang 2016, 175; Jeon et al. 2017). Many reasons have been cited for this high rate, but the main factor is believed to be the country's nascent pension regime. Many elderly people do not benefit from the scheme because of the short time it has been in existence, its inefficient administration, and its narrow eligibility criteria, as a result of which almost half the population aged between 19 and 59 years do not qualify (Sung and Choi 2020, 171). The government introduced the basic old-age pension in 2008 to bridge this gap, but by 2019 the amount paid out per month remained at 300,000 won (equivalent to 250 US dollars).

Care becomes a critical issue when elderly people are beset by health problems. As in other countries (Traphagan 2004, 57–77; Davies 2017, 143–44), in South Korea the elderly prefer to live by themselves while maintaining close contact with their children (Prendergast 2005, 73–96). When health problems strike, however, this arrangement becomes untenable amid dwindling family sizes and the rising number of women, i.e., the group who used to undertake this domestic care work, now going out to work (Park and Lee 2015, 851–54). Moreover, unlike in the past, when parental care was the family's responsibility, there is growing public sentiment that the state should care for the infirm elderly (Park and Kwak 2019, 238). From a public health perspective, it is also generally agreed that the high proportion of elderly people in the population puts a strain on the country's health system (Moon 2008, 146–47).

It is in light of these challenges that the long-term care hospital comes into full view. In 2000, these hospitals numbered 60; by 2018 they had grown to 1,560, accounting for about 40% of the country's hospital-level institutions. Today, they constitute the mainstream form of care provision in the healthcare landscape, both as major service providers operating within the NHI system and as large workforce employers. From the perspective of the Korean government their growth is a policy success, primarily because they have helped it to solve the thorny issue of 'bed-blocking', i.e., the problem of tertiary hospitals being flooded with elderly patients (Song 2012, 118). However, by making their role ambiguous, the government left open the possibility of LCHs being turned into medicalised nursing homes. In addition, by attracting a large number of non-medical actors into the hospital sector, via medical foundations which are permitted to run LCHs, the government instigated the large-scale commercialisation of the sector. For those seeking profits and status, the NHI-linked LCH is an attractive business option, especially when plenty of Korean-speaking migrant Chinese workers are available to work as caregivers (Seol and Skrentny 2009, 153–54).

## A hospital with ambiguous functions

The key to the expansion of LCHs lies in the, almost strategic, ambiguity of their function. The Korean Medical Service Act 2021<sup>3</sup> classifies them as a type of hospital-level institution that ‘has beds necessary for the *medical care* of patients needing long-term admission’ (Paragraph 2 of Article 3). So legally, they are hospitals for patients who require long-term care. However, in the government’s specifications regarding the law’s implementation, people admitted to these hospitals are defined as ‘patients suffering from senile diseases, chronic illness and those needing convalescence after surgery or accidents’ (Song 2012, 114–15). Thus, there are certain conditions that clearly qualify for admission, such as kidney failure where dialysis is needed, post-operative recovery, neurological conditions such as stroke and Guillain–Barré syndrome, and physical injuries—ailments that need observation but whose chronic nature does not warrant day-to-day treatment intervention. In contrast, the boundaries of what constitutes ‘senile diseases’ is unclear, encompassing as they can any condition caused by the ageing process, such as diabetes, hypertension, and mild forms of dementia. Not surprisingly, although the precise case mix will vary between LCHs, their main patient body consists of the elderly. Hence, the public equate them with hospitals for the elderly.

As hospitals, the LCHs are ‘low spec’ in terms of personnel and equipment. Their staff-to-patient ratio is laxer than that in regular hospitals, their respective doctor-to-patient ratios being 1:40 and 1:20 and their respective nurse-to-patient ratios being 1:6 and 1:2.5. Furthermore, 70% of their nursing roles can be staffed by nurse assistants (Song 2012, 119), who gain their certificate to practice following a year of training after completing their high-school diploma. LCHs are also subject to different NHI reimbursement methods. While services at regular hospitals are reimbursed on a fee-for-service basis, LCHs are reimbursed according to the number of days a patient is in hospital, with weighting applied according to both the grade of the hospital (based on its staff-to-patient ratio) and the severity of a patient’s illness: the higher the number of doctors and nurses and the more severe the patient’s condition, the higher the *per diem* reimbursements the hospitals receive through the NHI system.

Because LCHs play the roles of rehabilitation clinic, long-term care centre, and nursing home simultaneously, Western equivalents are difficult to find. Compared with Western nursing homes, whose 30 to 50 occupants are visited by physicians weekly or when the need arises, LCHs cater for larger numbers (from 100 to 400 or more) and employ full-time medical staff. Most importantly, those admitted to

3 Available on [www.law.go.kr/법령/의료법](http://www.law.go.kr/법령/의료법).

LCHs are designated as ‘patients’ as opposed to ‘residents’. Nevertheless, there are some Western institutions that bear a resemblance, as is the case with Dutch nursing homes (Song 2012, 118). In the Netherlands, these facilities employ physicians specialising in nursing home medicine full time, have a doctor to patient ratio of 1:100, and offer services including rehabilitation while functioning as a hub for geriatric social services (Conroy et al. 2009; Song 2012, 115–16). In addition, the many Korean LCHs that care for bedridden patients with minimal or no sign of active consciousness—or those in what medical anthropologist Sharon Kaufman (2005, 273–17) calls ‘the zone of indistinction’—can be said to resemble specialised care units in the US. However, unlike their Dutch counterparts, LCHs have no physicians who specialise in geriatrics, nor do they function as a hub for social services; and in contrast with the US’s specialised care units, which operate as part of a larger hospital, Korean LCHs are free-standing institutions.

## **The explosive growth in LCHs and their effect on healthcare and medicine**

Because of optimism around the anticipated implementation of Korea’s long-term care insurance policy in 2008, the number of LCHs began to increase substantially after 2005 (Ahn et al. 2015, 3). The government encouraged this, first by relaxing regulations concerning personnel and facilities (Heo 2018) and then by providing low-interest loans to existing hospitals to cover the cost of converting to LCHs (Chung 2007). This deregulation paved the way for non-medical actors to enter the medical sector, legally classified as not-for-profit (Moon 2008, 265), and to establish charitable medical foundations that would operate their new hospitals. This they did, using various rule-bending tricks common in the business sphere, including lobbying the local government charged with granting permission to establish foundations and filling positions on supposedly independent supervisory boards with their acquaintances. As a result, about 40% of all LCHs in 2015 were operated by these medical foundations (Ahn et al. 2015, 30)—a situation that can only be described as a *de facto* semi-privatisation of the sector.

If opening up the market was intended to expand the sector, which in 2000 had just 19 hospitals (Song 2012, 114), the incentives intended to promote transition were motivated by factors intrinsic to the business side of hospitals and specifically to the difficulty of surviving in a polarised sector. In a healthcare system in which state-owned hospital beds account for only 20% of the nation’s hospital beds (Kim 2005, 563), and where the role division between healthcare generalist and specialist physicians functions suboptimally in the context of the user-driven system (Moon 2008, 246), hospitals were essentially vying for the same patients. This led to a situation where patients were patronising large, tertiary-level institutions with good facilities even for ailments that could be managed locally.

Following the 1980s, these circumstances resulted in an expansion in university hospitals and hospitals sponsored by conglomerates or by financially stable religious organisations (Moon 2008, 252). Consequently, what are now referred to as ‘the Big Five’—namely the Samsung Medical Centre established by Samsung, Hyundai’s Seoul Asan Hospital, Seoul National University Hospital, Yonsei University Severance Hospital, and Catholic University Hospital (Kang et al. 2018, 48–9)—began to emerge. In the 2000s in particular, when Samsung and Hyundai became global powerhouses, large infrastructure investments were made, with university hospitals following suit, further polarising the market. In the era of population ageing, however, this meant that the big hospitals became inundated with elderly patients while small and medium hospitals had difficulty filling their beds. From the perspective of these hospital owners, converting their struggling hospitals to LCHs with government money thus made sense.

Given the ambiguity of the LCHs’ function, and the semi-privatisation measures implemented to promote them, it is not difficult to imagine what their explosive growth has entailed. As mentioned above, these LCHs are designated as medical facilities. Therefore, concerns about what the government calls ‘social admissions’—defined as ‘hospital admissions of those whose disabilities are not medically recognised to use care facilities’ (Choi and Lee 2010, 856) or the ‘hospital admission of those who do not need it’ (Kwon, Park, and Lee 2015, 105)—are not surprising. According to one estimate, one in ten LCH patients is admitted for social reasons, such as for help with daily living and respite, rather than for medical treatment (Min 2018). In reality, the proportion is probably much higher. In one LCH in which I worked, for example, an NHI official issued a verbal warning to the non-medical hospital owner that approximately 60% of the hospital’s patients should be transferred to an LCC, implying that in that particular LCH, significant resources were being spent on ‘caring’.

Competition between LCHs, combined with an influx of profit-seeking actors, led to the proliferation of illegal practices aimed at cost-reduction and patient recruitment—both of which had been reasonably well controlled when the hospital sector was populated only by medics and religious organisations. These practices included faking the number of medical personnel in order to receive a higher hospital grade, providing discounts on fees, and cutting back on subsidised meal expenses. Knowing these practices well, a group of LCH patients was even reported to have negotiated the terms of their admission with hospital owners in return for financial kickbacks (Park 2018). The government has since introduced various measures to curtail these practices. Nevertheless, the degree of commercialisation that can be observed seems greater than that in the past, raising concerns that full commercialisation of the country’s healthcare may be imminent unless this trend is checked.

It has been said that medical practice in Korea shows 'free market' characteristics 'even under the national health insurance system' (Kim 2005, 564). One reason behind its commercial outlook can be found in the way the market operates. In Korea, competition between clinics in the non-NHI section of clinical practice, such as plastic surgery and health screening, drives the market. The popularity of these non-NHI services, which account for 35% of total healthcare expenditure, fluctuates. However, as exemplified by the recent inclusion of MRI and CT in the NHI system following the expansion of the screening market, the NHI authorities and the health ministry may be tempted, or even incentivised, to take on these kinds of services, applying economies of scale as the cost of these services is driven down through competition. For its part, the government has contributed to this commercialisation by promoting medical tourism (Jeong 2010, 54) and by constructing medical industry complexes in the name of 'developing medical industries to the level of advanced state' (Kim 2014, 279–80, 296).

LCH-driven commercialisation is different from these initiatives because the latter, despite their profit motives, still conceive of the system as one of medical practice in which doctors play a central role without explicit outside interference. The LCH regime disrupts the unwritten contract between the state and the medical profession by allowing non-medical actors to exert control over the practice of medicine for purely commercial reasons. Indeed, with their recent success in the private health insurance market, some corporate actors could feel emboldened to seek entry into the medical business on the basis of the precedent set by the LCHs. In such circumstances it is not inconceivable that the Korean healthcare field will repeat what its US counterpart experienced in the 1990s, when stock market money streamed into the hospital sector (Shin 2005, S101). This is why changes to the LCH system should be seen against the wider backdrop of healthcare privatisation; and why the resulting emergence of Korean-style commodification of elderly care should be viewed in the context of structural changes taking place in the sphere of medical business-making.

In the realm of healthcare administration, the biggest impact of LCHs can be seen in terms of the workforce. Quite simply, the expansion of the sector has created many jobs. Doctors are being employed in their 80s, and many are happy to settle in paid positions without opening their own 'solo' medical practices. In addition, because LCHs focus on care, nurses have started to assume greater responsibility. In one LCH where I worked, for example, I witnessed an elderly surgeon being angry at a head nurse's insistence that he prescribe certain drugs. The surgeon, who had joined the hospital recently, was particularly angry about the way the registered nurse, who had been there for over a decade, acted as if she had more authority over the patient than he did. Her attitude, however, was well known among the other physicians, who generally acquiesced to her

demands. As up to two-thirds of LCH nursing staff can be made up of nurse assistants, many of them take on roles normally assigned to registered nurses. On one occasion I even observed a nurse assistant insert a feeding tube into a patient—a procedure usually performed by physicians and permitted to nurses only in limited circumstances (Cho and Kim 2016, 392)—breaching what social anthropologist William Caudill (1958, 7) termed ‘the mobility block’, or the blocking of performing roles that cross professional boundaries in hospitals. These cases demonstrate that by participating in the LCH regime the Korean medical profession has traded its authority, the quintessential symbol of medical power (Freidson 1988), for financial gain. These cases also corroborate the claim that biomedical practice manifests in different ways, according to the local contexts in which it functions.

## **Living and dying in hospital**

LCHs have largely become hospitals for the elderly and, for many, places of living. I will now present a snapshot of life in an LCH to highlight its nursing home function. The details reported may not reflect the ‘typical’ ways in which patients are cared for, but they nevertheless give an insight into the conditions under which elderly people are cared for in a hospital environment. In this particular LCH, which I call Hospital K, I worked for ten months as one of nine full-time physicians, charged with the Korean medicine-based care of about 80 patients.

Hospital K is a rural LCH, established in 2004 by a former employee of a conglomerate company that went bankrupt during the economic crisis of 1997. After a stint in the welfare centre business the owner wanted to move to the ‘respectable side’ of the business, and an opportunity to do so opened up with the government’s LCH promotion measures. After purchasing the site of a primary school that had been abandoned because of the absence of school-age children in the area, the new owner converted it into a hospital, hiring his co-workers who had been laid off during the crisis. The institution started out with 29 patients, but by 2016 this number had increased to 360. According to the owner’s own categorisation, 150 of these patients needed long-term care, 140 rehabilitation and 77 cancer treatment. To care for these patients, nine physicians—six doctors of medicine (MDs) and three doctors of Korean medicine (KMDs)—were employed, in addition to 119 nursing staff, 34 physical therapists, 100 full-time caregivers, one medical technician, one social worker, one pastor, and 10–15 administrative staff. With a brand new 80-bed cancer ward opening in 2017, the hospital has become the province’s biggest LCH, with a total capacity of 450 beds.

The 150 patients whom the owner categorised as ‘needing long-term care’ are the patients to whom this hospital gives ‘care’. To an experienced clinician like me,

however, the idea that hospitals can be a place of living initially sounded absurd. I first learned of the idea in 2012, when I overheard a conversation while travelling in a bus to a local temple—I was doing fieldwork in Korea as part of my research training in England. The passengers, who were in their 50s, were on a hiking trip and were talking about parental care:

Man A: [Someone's] father must be in a long-term hospital?

Woman B: Father or father-in-law?

Woman C: It doesn't matter. Whether father-in-law or your own father, you can't live together. You can't manage it.

Woman B: It might be quite hard for the children.

Woman C: It is not just 'hard', it's impossible.

Man D: They [LCH] must not be that expensive?

Woman E: Some with good facilities are expensive though.

Man E: Government gives a lot of support [to LCH].

Because this conversation piqued my interest, I decided that I would work in these kinds of hospital on my return from England. The world of LCHs was novel to me, someone who regarded a hospital as a place of acute care. For jobseekers in my profession there was even an 'LCH job guide', which contained such common sense-defying expressions as 'Don't work too hard as it will lead to the collective degradation of working conditions', or 'Work experience and credentials will not impress the owner'. Interspersed with these were warnings against illegal business practices. From my experiences during the job search, I felt that the LCH owners were considerably more interested in money-making than in providing good patient care. During my interview, for example, the non-medical owner of Hospital K emphasised the social rather than the medical function of his hospital, stating that LCH are not places for treatment and that therefore he did not need physicians with sophisticated skills. This 'not for treatment' characterisation of LCHs even became the subject of a joke among my fellow doctors in Hospital K, when one elderly gynaecologist—who had acquired an additional specialist qualification in family medicine by means of written examinations rather than through clinical training—remarked during a post-lunch stroll that this qualification, just like our doctors' licenses, only exists 'on paper' and so is not 'real'.

At Hospital K, the daily routine begins with the arrival of a bus carrying staff to the hospital by 08:30. By this time the patients have already been served their breakfast. Around 9 a.m., nurses dispense medicines, providing shots and fluids

to the patients. After that, the daily rounds by MDs and KMDs are carried out. Patients then take their weekly bath with the help of the caregivers, who are each in charge of five to eight patients. After lunch is served, at midday for staff and half an hour earlier for patients, there is a long break until 14:00. The afternoon is filled with physical therapy sessions, for which patients are transferred by the therapists to a rehabilitation centre; for those in intensive care, the therapists work at their bedside. In between these schedules, activities take place; these might include a ward-level religious service organised by the resident pastor, film watching, concerts, or a birthday party, held in the multi-purpose hall. Patients can also make use of a spacious playground, equipped with a singing room and gateball facilities. Dinner is served at 16:30 and then the staff depart for home on the bus at 17:00, marking the end of the working day for most of them.

But for the presence of physicians, this routine would resemble that of a nursing home. That is why the public sometimes cannot distinguish LCHs from LCCs, the latter being more similar to a traditional nursing home. The following dialogue from a clip in a TV programme depicts a family dispute about a mother suffering from dementia. In a fictional manner, it reveals the extent to which the role of LCHs overlaps with that of LCCs:

Daughter: It looks like we should admit our mother to a long-term care hospital (*yoyangbyöngwǒn*).

Father: Why should your mother go to a long-term care centre (*yoyangwǒn*)?

Daughter: In LCH (*yoyangbyöngwǒn*), there are physicians ...

Daughter (in monologue): Afterwards, I could not raise the issue of LCC (*yoyangwǒn*) with my father.

Initially, the daughter had expressed the difference between LCHs and LCCs in Korean using precise terms. However, when faced with her father's angry response she suddenly referred to the LCH as an LCC, reflecting the lack of clear differentiation between the roles of these two institutions in the minds of the public.

Some of the patients in Hospital K have been there for a long time, relying heavily on staff for their daily activities and with no immediate plans to be discharged. Even when they are discharged, many go on to another LCH. That is why, after the first few months of my work, I learn to be careful not to say words of encouragement to patients such as, 'You should be able to go home soon!' Having become so accustomed to helping patients in the LCH move around in their wheelchairs, I was struck when I was told off by a patient for doing the same in a rehabilitation hospital I subsequently worked in; the patient refused my help because he had been admitted to the hospital to regain his independence.

Patient S, an 83-year-old lady with a mild stroke and deteriorating joints, has been in Hospital K for ten years. One day, after her son's visit, she remarked to me,

A few days ago, when my son came over, I told him that I wanted to go home. Then he said, 'Why don't you stay here until I am 50?' He is now 49 and wants me to stay for one more year. He said, 'Nobody will be able to take care of you if you are home. Who would serve you meals and cater to your daily needs, not to mention your medical needs?'

It is likely that she will continue to stay, possibly until her death. At 600,000 won per month<sup>4</sup>, plus a caregiving fee of 300,000 won, her medical as well as her social care needs are being met. Plus, her son visits her often. Judging from my interactions with her son, he seems to be happy with the current arrangements, despite the facility being dilapidated and his mother's lack of privacy through sharing a room with seven others. In urban LCHs with good facilities, where rooms are occupied by four to six patients, the monthly hospital fee alone exceeds one million won. Still, for families with relatives whose conditions need supervision, LCHs are regarded as an economical option, particularly when LCCs charge similar fees (Kim et al. 2013, 14, 36) but cannot meet their medical needs.

When the nursing home function of LCHs is combined with a lack of oversight, situations that contradict the institution's 'hospital' status arise. An elderly patient who is alert and communicates well refuses my treatment on one occasion. Despite having mild dementia and a history of strokes, her downright refusal feels strange, so I follow it up. I discover that she has drunk too much wine, given to her by the hospital owner's wife earlier that day. On another occasion, I am shocked to discover that an elderly man who eats alongside us in the staff canteen is actually a patient admitted to the hospital 13 years ago. Because he frequently leaves the hospital, sometimes on a bicycle (!), I never imagined that he changes into a patient's uniform in the evenings.

From the perspective of the patients, however, this medicalised living arrangement is never satisfactory. In one study of LCHs, family members expressed their dissatisfaction with aspects such as the lack of personalised attention, privacy, and hygiene, the inadequate safety measures, and the passive attitude to managing patient's condition (Kwon, Park, and Lee 2015, 114–18). Although ethnographies carried out in nursing homes in the UK and the US (e.g., McLean 2007; Davies 2017) have revealed some degree of privacy to be possible in Western nursing homes, there is no privacy in LCHs. This is because patients in the latter are under medical surveillance, including pharmacological control. The case of patient Y, an 83-year-old former primary-school teacher suffering from mild dementia, illustrates

4 The average cost of LCHs ranges from 400,000 to 600,000 won a month (Kim et al. 2013, 14).

the point. Fully mobile by herself, and with her mental capacity barely compromised, she usually draws the best pictures in activity sessions. To make her institutional life bearable she takes a keen interest in activities that include watching films, although she confided to me that she finds many of the films that are shown boring and wants to watch those ‘showing classic England’—presumably, given her age and educational level, she refers to the ones based on Jane Austen’s novels. Although she is not religious, she reads the Bible, and one autumn day I even taught her to play gateball as she lingered near the lawn. From the staff’s perspective, however, her mental alertness is a problem rather than a laudable sign of health because she frequently reports sadness and depression. As a result, the nurses and her physician classify her as a ‘difficult’ patient. Known within the LCH as a fan of psychotropic drugs, her doctor prescribes antidepressants whenever she complains, taking the tally of her daily tablets to eleven.

The fact that many elderly patients consider LCHs as places for living means that they are also likely to be their place of death. According to a study of 122,531 people aged over 65 who died in 2017, the average number of days spent in either an LCH or an LCC in the last ten years of their life was 661 days—up from 593 days recorded in a similar sample for the previous year (Seo 2018)—a high proportion of these days presumably concentrated in their final years. Although exact figures are not available, an increasing number of elderly people are dying in LCHs. For this reason, many operate their own morgues. In another rural LCH I worked in, the morgue business was a substantial part of the hospital’s operations. I have observed many elderly patients, mostly from the local area, admitted in their final months or even days. Hospital K does not have its own morgue but sends its patients to big hospitals when their conditions deteriorate. For those who meet their death in Hospital K, their final moments are spent in the corner of its intensive care unit (ICU), euphemistically called the ‘VIP room’. Regardless of the ‘do not resuscitate’ wishes of the families, as the patients’ final moments approach, the staff often perform procedures to raise their blood pressure or compress their chest, until they are told explicitly by the family not to continue. This is done in order to avoid any legal liabilities.

This aspect of the LCH as a place of dying is exploited by some, recalling the ancient custom of abandoning the elderly, called the ‘koryŏ burial’ (*koryŏjang*). This is a supposed practice of Koryŏ Dynasty (918–1392 AD) origin, in which children abandon their parents in a forest (Janelli and Yim 2004, 135–36). In Hospital K, I encounter a similar scenario. One day, the physician in charge of the ICU angrily tells us about some people who have tried to have an old lady admitted, requesting that no therapeutic action be performed on her. The doctor rightly refused her admission on the grounds that he would administer nutrients if the patient

deteriorated. That is why, among doctors, LCHs with an unusually high proportion of very ill elderly patients are called ‘*koryŏjang* hospitals’, red-flagging them as places to avoid.

The ICU creates fear among the patients of Hospital K, because they know that if they are transferred to the unit their days will be numbered. Patient C is an 82-year-old woman suffering from chronic obstructive pulmonary disease. Because of a high fever and a dip in her blood oxygen level, she is transferred to the ICU one day. Clearly scared and in great anxiety, she grabs my hand and says: ‘They must have brought me here because they know I will die’. Fortunately, her condition improves and she returns to her ward. This does not occur often; empty beds generally mean the death of their occupants.

In Hospital K, family members can choose to have a prayer service, in which the pastor prays for the departing soul, at the deathbed of their relative. While usually at least one relative is present, some patients meet their death alone. Patient H, an 82-year-old lady, has been in ICU with minimal consciousness for a long time. What catches my attention is the information in her medical records provided either by her nephew, her only relative, or by the pastor who has taken care of her for 15 years. The records read,

Character: Very stubborn and does not listen to others.

Expectation: Doesn’t care how long she lives and will totally trust the hospital in this.

DNR (do not resuscitate): Affirmative.

Restraints: Affirmative.

Patient H passes away alone, with no family member present. The documents needed for her funeral are sent to her nephew. She has been practically abandoned. While a combination of factors would be at the bottom of this event, the case of Patient H invites us to reassess the current structures of LCHs governance that allowed this to happen.

## **Filial piety reconfigured**

As the place of care moves from the household to the hospital, and providers of care become paid caregivers and LCH staff, it is unsurprising to find that the practice of filial piety, or *hyo*—the concept that has underpinned the moral economy of parental care in East Asia for so long—has been transformed. Many LCHs have *hyo* in their name and promise that their institutions will serve their patients as their own children would. In 2014, 10% of LCHs were reported to have adopted *hyo* in their names (Shin 2014). Hospital K also displayed the concept

prominently on two stone tablets: in the first, the word is inscribed together with a word meaning loyalty; on the other, reflecting the hospital's Christian ethos, the biblical quotation from Mathew 19:19, 'Honour thy father and thy mother', is inscribed.

Before exploring the notion of filial piety in the LCH context, it is important to distinguish its ideological underpinnings, its function as a system of precepts aimed at social control, from the battery of virtues or affective elements that it embodies, such as 'respect, care and intimacy' (Lee 2014, 266). Both perspectives on this concept, as well as their differentiation from each other, are important to our discussion. That their differentiation is not arbitrary is demonstrated by Lim's (1988) cross-cultural comparative study of teenagers in the West and those in the East. Lim (1998) found that while Korean children showed more filial consciousness than Western children did, their degree of respect for their elders was, rather surprisingly, lower than that of their Western counterparts. This suggests that Korean children may have become acculturated to the ideological dimensions of filial piety while failing to cultivate the affective attitudes constituting the concept. Seen this way, the 'great strain' that Koreans feel under the pressure of filial piety, as well as their adaptive strategies aimed at saving face and deflecting criticism for not living up to the ideal, can be understood (Chung 2001, 151–52). The politics of this strain are also described in Yi Chong-jun's (1996) autobiographical novel *The Festival*, where the author is constantly chastised by two village elders whenever signs of procedural impropriety are observed in the management of his mother's funeral, seen by them as evidence of his failure to show true filial piety.

In the Confucian context in which filial piety has largely developed (Canda 2013, 213), its normative force is justified through the biological connection between parents and children. The opening chapter of the *Classic of Filial Piety* (孝經), the work ascribed to Confucius' disciple Zeng Zi (曾子) and probably compiled during the early Han period (202 BC–220 AD), expresses this logic well when it says,

Filial piety is the root of all virtues, and from which all teaching comes. [ ... ] *The body, the hair and skin are received from our parents, and we do not injure them. This is the beginning of filial piety. When we have established ourselves in the practice of the Way, so as to make our name famous in future generations and glorify our parents, this is the end of filial piety. Filial piety begins with the serving of our parents, continues with the serving of our ruler, and is completed with the establishment of our own character* (As cited in Lee 2004, 145–46; emphasis added).

According to this logic, Confucians argued that children must mourn at their parents' graves for three years because their parents expended their greatest efforts caring for them in their first three years of life (Deuchler 1992, 185). By drawing legitimisation on naturalistic grounds, filial piety has thus been able to function as a political ideology in a neo-Confucianised Korean society since the Chosŏn Dynasty (1392–1897 AD) (Deuchler 1992).

Thus, the stage is set for filial piety to serve as 'an efficient mechanism for the support of the aged' (Sorensen 2004, 157) or a quasi-legal contract underwriting the domestication of care. This 'welfare system' is perpetuated through ancestor rituals that the state has praised 'as the most filial act a son could perform for his parents' (Deuchler 1992, 175), while the 'hierarchical relationships among patrilineal kin' are sanctified through the dramatisation of filial acts manifested during the rituals (Kendall 1985, 167). Before the advent of LCHs, the moral economy of parental care can be said to have been underpinned by this system, in combination with the practice whereby the eldest son takes responsibility for his parents' care in return for the lion's share of the inheritance (Janelli 1982, 49).

In LCH-mediated parental care, the essential elements constituting the moral backbone of family relations remain the same, namely the children's care burden and the parents' wish to be with their children. The hikers' conversation, recounted earlier, is an illustration of the former. While serving as on-call physician in another LCH, I overheard a conversation that threw additional light onto this subject. As my office, without being labelled as such, was located next to the communal area I could often hear the patients' conversations. On one occasion, in the early hours of the night, the daughter of a patient in his 80s was chiding her father. Irritated by his night-time calls, she shouted, 'Why do you keep calling me at 3:00 in the morning? People do not die like that!' Despite the caregiver's attempt to ease the tension, emotions ran high while the daughter's father listened passively.

In Hospital K, parents' longing to be with their children was observed frequently. Patient D is a well-known troublemaker, due to her stealing and persistent demanding behaviour. Suffering from advanced dementia, she quarrels with others when delusional. Her son is the headmaster of a high school and visits her once a year, and one of the questions she asks her doctor daily is whether he has received a call about her son's upcoming visit. The nursing notes record her depression and suicidal wishes. In contrast to Patient D, Patient J, who is suffering from Parkinson's disease, is calm and soft. However, she too expresses her yearning to see her son in an unusual way, in that she hallucinates hearing his voice. Every time this occurs, she dashes out of her room, walks speedily to the hospital front gate, and then injures herself by falling on the ground. I learn of her

dangerous trips after I see her blood-covered face one day as she ambles back to her ward assisted by nurses.

As the site of care has moved from home to the LCH, its guiding principle from ideological filial piety to the principles of market economy, it is unsurprising to see the notion of filial piety being reconfigured. The staff of Hospital K defined filial piety primarily in terms of their patients' children's compliance with the institutional care it offered, a view they said they shared with other LCH workers. According to them, 'filial sons' visit their parents frequently and hence have a good relationship with the staff, the implication being that there will be no major complaints even if some adverse event, such as a fall, should occur. The belief is that the children have an appropriate level of expectations concerning the services provided. The son of Patient S, who has been there for ten years, belongs to this group. He is happy with the service and hence is a 'filial son'. In contrast, 'unfilial sons' rarely visit, have no rapport with the staff, and thus have abnormally high expectations. As a consequence, they lodge substantial complaints whenever something happens. The headmaster, Patient D's son, belongs to this group and the staff tell me that the entire hospital is on alert on the day of his visit. The staff have him firmly categorised as an 'unfilial son', although to me both elderly ladies looked to be equally unsatisfied with, or even deeply depressed at, their living conditions.

In a nutshell, LCH staff judge filial piety according to the degrees to which the patients' children trust them both as the commercial mediator of family relations and as the surrogate caregiver. In other words, by refashioning the concept to accommodate the notion of service, i.e., allowing children to bypass the ethically charged parent-child relationship, LCH staff conspire to absolve them of their failure to respect their parents' wishes concerning the living arrangements.

## **Coda**

Frustrated with failures in US healthcare reform, Robert Alford (1976) reviewed two decades of attempts by New York City to reform its healthcare infrastructures, only to find that the actions of the parties concerned were geared more towards sustaining or expanding their own interests than to effecting fundamental change. Arguing that the same trend could be observed nationally, he highlighted three major healthcare interests in a market society. The first are 'the corporate rationalisers', such as state bureaucrats, hospital administrators, and the researchers serving them, who seek administrative efficiency and the rational organisation of resources. The second are the 'dominant interests', who occupy a dominant position in service provision, i.e., the medical profession. The third are the 'repressed interests', such as the community, for whom reforms are implemented but whose voices are eventually drowned out.

His arguments ring true in our stories of the elderly care provided by LCHs. Here, it is easy to recognise whose interests are being served: the state's interests are served as, in the absence of welfare infrastructures, the hospitalised care regime directs the pressures applied on the tertiary hospital sector by population ageing to the LCHs; the interests of the medical profession are also served, through the state's support of the LCH business model and the additional employment opportunities LCHs give rise to—although doctors must compromise their medical authority in settings where care takes precedence over medical skill; and we find that adult children's interests are served, as NHI-financed LCHs not only take on their duty of care at a subsidised cost but also absolve them of their failure to respect their parents' wishes under the façade of providing medical care. Sadly, it is apparent that the only ones whose interests are not served are the elderly. On the contrary, as Alford argued, their interests are 'repressed', as they are hurried into hospital beds and put under medical control.

This research article has introduced a new type of hospital in South Korea that sits at the centre of all these concerns. These hospitals play the combined role of rehabilitative hospital, long-term care centre, and nursing home. As explained, their growth, which has recently exploded, was aided by both the absence of elderly care infrastructures and business conditions in the hospital sector. This and their subsequent hom(e)fication is attributable in part to the government's blurring of medical and social care when creating this institutional entity and in part to the influx of profit-seeking actors following the sector's *de facto* semi-privatisation. Falling out of this, the article discussed how the sector's success has led to the emergence of a Korean style of elderly care commodification centred on hospitalisation, revealing the undercurrents of healthcare privatisation and the neoliberalisation of welfare.

Drawing on these findings, the article went on to reveal how the hospital-based care regime has influenced healthcare and medicine as well as the moral economy of parental care in the Korean context. This is important, because LCHs function officially as places for 'medical care' and operate on a non-profit basis. However, the data presented suggest otherwise, revealing that these institutions were conceived from the outset as entities straddling the realms of medical and social care, and that many of them ended up becoming medicalised nursing homes intent on making profits. Moreover, the competition between them continues to further commercialise the medical field. The ethnographic exploration of life at one particular LCH showed that in these settings, where care is prioritised, the practice of medicine manifests differently, i.e., in a way that diminishes the authority of doctors and strengthens that of nurses. Finally, the article ends with an illustration of how the hospitalised care regime has reconfigured the norm of filial piety, using

the market idiom of service, in the context of the new moral economy of parental care.

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