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**MENTAL HEALTH POLICY MAKING IN SOUTH KOREA:
STRUCTURAL AND CULTURAL INFLUENCES**

by

Chang-Sik Shin, BA. MA.

Thesis Submitted to the University of Nottingham

for the Degree of Doctor of Philosophy

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Abstract

This study focuses on the way in which rapid structural changes (such as economic development, urbanisation and other demographic factors, and the economic crisis of 1997) have raised issues that are seen to require a social policy response in the mental health care arena under Confucian governance in South Korea. These structural changes happened over a couple of hundred years in Western Europe but have taken place over only the past 40 years in Korea. The main thrust of the study is on the extent to which the decisions about policy responses to perceived social problems, especially the increasing number of people with mental health problems, are structurally driven or the extent to which they are informed and shaped by Korean politics and culture.

The industrial and economic base of Korea grew dramatically until the late 1990s. This facilitated the development of social policies – particularly in areas such as education, health and housing, which support economic growth. However, although the structure of the family changed to be closer to its structure in the West, it could be argued that evidence pointing to a broader ‘Westernisation’ of Korean society was premature. Confucianism may have been a factor in Korea’s development, but it may yet prove a hindrance to any further moves to modernity and equalisation of life chances amongst its citizens.

Since the economic crisis of 1997, Korea has experienced a rapid expansion of social welfare provision following a series of reforms. These reforms have gone beyond the functional minima necessary to deal with social problems caused by the economic crisis. However, the government has tended to stress the greater role played by family

members, particularly women, in providing care to their elderly relatives, and the desirability of multigenerational households over nuclear families. A similar emphasis on the caring roles of the family and community is also seen in the Korean state's renewed public emphasis on the country's Confucian cultural tradition.

As a result of this, there has been a tension between the increased emphasis given to the role of the informal carer within mental health policy as the Korean government has introduced a community-based scheme which assumes that families want to care and those with mental health problems want to be cared for by their families. Accordingly, the main burden of care falls upon women. This still tends to be ignored by policy makers.

Despite the country's rapid demographic, economic and social changes, there has been a widening gap between the population's expectations and needs and health and social service provision in the mental health arena. Neither long-term care services nor personal social services are well developed for those with long-term mental health problems. In addition there is a marked disparity between the acute services, which are predominantly provided by private sector organisations in a highly competitive market and broadly achieve high standards, and public primary care and rudimentary residential services in the mental health arena. In this context, it could be argued that Korean mental health policy is concerned with maintaining social order rather than care and treatment of those with mental health problems.

Abbreviations

| | |
|--------|---------------------------------------------------------------------------------|
| CMHCs | Community Mental Health Centres |
| EIS | Employment Insurance System |
| EOI | Export Oriented Industrialisation |
| EPB | Economic Planning Board, Korean Government |
| DJ | (Kim) Dae Jung: Former President of South Korea (1998-2003) |
| GDP | Gross Domestic Product |
| GHCs | General Health Centres |
| HCI | Heavy and Chemical Industries |
| IBRD | International Bank for Reconstruction and Development |
| IMF | International Monetary Fund |
| KDI | Korea Development Institute |
| KIHASA | Korea Institute for Health and Social Affairs |
| MOHSA | Ministry of Health and Social Affairs, Korean Government |
| MOHW | Ministry of Health and Welfare, Korean Government (Renamed on 23 December 1994) |
| MOL | Ministry of Labour |
| MOPB | Ministry of Planning and Budget |
| NBLSA | National Basic Livelihood Security Act |
| NICs | Newly Industrialised Countries |
| NGO | Non Governmental Organisation |
| NHI | National Health Insurance |
| NOS | National Statistics Office |
| NP | National Pension |
| OECD | Organisation for Economic Co-operation and Development |
| SRCs | Social Rehabilitation Centres |
| WHO | World Health Organisation |
| WII | Work Injury Insurance |

Chapter 1. Introduction

1.1. Background of the Study

In this study, the main focus is on the way in which rapid structural changes (such as economic development, urbanisation and other demographic factors, and the economic crisis of 1997) have raised issues that are seen to require a social policy response in the mental health care arena under Confucian governance in South Korea (henceforth Korea). These structural changes happened over a couple of hundred years in Western Europe but have taken place over only the past 40 years in Korea. The main thrust of the study is on the extent to which the decisions about policy responses to perceived social problems, especially the increasing number of people with mental health problems, are structurally driven or the extent to which they are informed and shaped by Korean politics and culture.

Since the 1960s Korea has experienced rapid economic growth alongside the three other 'tigers', Hong Kong, Taiwan and Singapore. Korea is known as one of the most successful cases of intentional economic growth. Over three and a half decades, from 1961 to 1996, it grew from a country ravaged by war to the world's 11th largest economy with a per capita gross domestic product exceeding US\$10,000 and is now a member of the rich nations' club, the OECD. Korea has actively adopted various aspects of Western social welfare programmes into its own systems according to their prospective cultural, political and social backgrounds.

Over this time period, social and economic changes have occurred in many areas of Korean society, these include the social service system, health care system and governmental structure. Many social programmes, such as public assistance, social security, welfare for individuals with psychological and developmental disabilities and health care insurance were established. This illustrates that there has been an increasing emphasis placed on governmental responsibilities. However, social development still lags far behind economic growth, even though Korea has achieved remarkable economic growth over the last three decades (Kwon, S. W. 1993; Goodman and Peng, 1996; Yousefi, 1997).

The growth of capitalism and mass democracy is an important historical force behind the emergence of the welfare state in Western societies. Also, it is said that 'as the degree and the method of responsibility for meeting social needs varies from country to country, historical and socio-cultural conditions are important in determining the particular shape of their social welfare systems' (Sherer 1987, pp.290-1). As noted, unlike other advanced countries across Western Europe and North America, Korea has experienced considerable social and economic changes (industrialisation and urbanisation) over a very short period of time.

The appearance of state policies for those with mental health problems in the Korean welfare regime shares much with advanced Western welfare regimes. This is mainly because they have been initiated under international pressures for protecting the individual human rights of those with mental health problems and promoting mental health care provision. Despite the superficial similarity, their practical functioning, in

reality, is inextricably bound up with socio-cultural traditions in Korean society.

Along with the expansion of welfare policy programmes, Korean mental health policy and practice has been developed to protect individual human rights alongside reasons of social order. To achieve this goal the Korean government established its mental health policy and formulated mental health legislation to provide those with mental health problems with care services. The government aimed in this way to overcome the disparity between the needs of people with mental health problems and the availability of services. In the wake of the economic crisis of 1997, Korea had to manage a financial moratorium with the help of the IMF. Under these circumstances, Korean welfare programmes, including mental health care, were constrained by budgetary considerations.

Within this socio-economic context, significant changes have occurred in the mental health care system. In December 1995 the Mental Health Act was passed for the first time and the act has been in operation since March 1997. Traditionally, mental health care in Korea was hospital-centred, characterised by long in-patient stays and insufficient support services to allow people with mental health problems to live in the community. In addition, if a physician believed that an individual was able to leave the hospital, the family would have to accept responsibility for the care and protection of the relative. Beginning in the late 1990s, community integration of people with mental health problems became an official goal of Korean mental health policy. This integration requires significant changes in the Korean value system and service organisation of mental health services. In order to achieve this goal, the community mental health system has been established. The community mental health service

system includes social rehabilitation centres for people with mental health problems, community mental health centres and 'general' health centres.

With the creation of an industrial society, the concentration of the population into urban centres, the urgent and massive social problems arising from phenomenally rapid urbanisation, and the undermining of more traditional family and community systems of social support and control have resulted in the problems of welfare becoming a societal rather than a family problem. Nevertheless, the development of social policy continues to be facilitated by Confucian values. In Korean society, citizens are under strong moral and, sometimes, political pressure to keep familial problems within the family and to abstain from resorting to social or governmental measures in an effort to meet familial needs (Kim, 1990; Chung, 1991). Apparently, the Korean family, which is strongly rooted in a Confucian ideal, is itself a serious problem which needs to be solved by state intervention, rather than a problem-solver, which the Korean welfare regime had assumed.

More importantly, the Korean welfare regime is grounded on 'the minimisation of state responsibility and the maximisation of family responsibility' as the cornerstone for social provision, underpinned by Confucian familism (Won, 2004). Based on this logic, the Korean welfare regime has given way to the family or the private sector bearing responsibility for social provision (Jones, 1993; Goodman and Peng, 1996; Goodman, White and Kwon, 1998; Kwon, 1997, 1998; Kim, Soo-Young, 2000; Lee, K. A., 2001; Sung, S. R., 2002).

The political structure's emphasis on economic development makes it difficult to

moderate any social stress factors through the development of a countervailing social welfare infrastructure. There has indeed been a deliberate governmental strategy not to develop a supporting social infrastructure or a modern welfare state package of social services and income policy programme such as might assist the elderly and their informal caregivers. It could be argued that Korea retains a strong cultural tradition and repeated affirmation of the values and practice of Confucianism. In this respect this feature will be considered in relation to the way mental health policy has been addressed. In addition, this study considers the extent to which the Korean government is truly Confucianist or whether it embraces Confucianism in certain policy areas because it suits them to do so in terms of benefit to the state.

1.2. Significance of the Study

The case of Korea can be especially worth investigating among the East Asian countries, given the fact that the economy developed so fast and so effectively up to the end of 1997 and then fell so heavily in the wake of the financial crisis. This study might provide an interesting test case for the debate on the globalisation hypothesis, which suggests that the role of the state will decrease. Also this study might enable us to put Korean mental health policy onto the map of international comparison.

There has been for some time a call for systematic research on the emerging Korean welfare systems. Recent studies (Kwon, 1995; Goodman and Peng, 1996) have started a systematic analysis, but we are still a long way from a systematic understanding of mental health policy in Korea. There are two features of special interest in Korea. As in

other East Asian countries, there is a strong cultural tradition and repeated affirmation of the values and practices of Confucianism. The first is that, among its many expressions, it leads governments to assert that the family is and should be responsible for the material support and care of people with enduring/ongoing mental health problems and therefore claim that it is not necessary to develop social security, income support or formal care services for people with mental health problems. Secondly, the enthusiastic pursuit of a capitalist model of economic development with strong influences from the United States has encouraged even Korea's 'responsible' government to argue that their primary responsibility is to create a legal and fiscal environment that is conducive to business, which translates into low personal and corporate taxation and a minimal welfare state.

This study examines factors which contribute to policy making in the mental health arena. This might enable us to put Korean mental health policy onto the map of international comparison. Also relatively few resources are currently available which enable the examination of mental health programmes and policies in Korea. One of the aims of this study is to provide the reader with up-to-date information on mental health policy and practice outside Western European and North American countries. This study will attempt to enrich our understanding of mental health policy as the development of mental health services has dealt fairly exclusively with a limited number of countries. A great deal of research has been conducted on the mental health policy of countries in Western Europe and North America to the extent that our understanding of the mental health policy in these countries can be described as comprehensive. Mental health policy in other countries, especially East Asian countries, has been given far less attention than their economies and politics. In connection with this, the study will help

broaden the base of understanding of mental health policy. Only Korea will be analysed in depth, but its mental health policy analysis will highlight how it differs markedly from other countries.

This study will be interesting on a number of fronts. First, the policy examined (the introduction of community mental health centres) is an approach which failed in the USA and the reasoning behind its introduction in Korea bears examination. Second, there is a specific cultural focus upon a Confucianist policy approach, which may have been adopted as a cloak to justify cost cutting (like Scull). Third, the thesis could provide a vehicle for understanding the policy process in South Korea, similar to the contribution of Hall, Land, Parker and Webb's *'Change, Choice and Conflict in Social Policy'* – though that policy framework is not specifically adopted. Fourth, explanatory international models of mental health policy have largely ignored Asia and this work could provide a useful contribution.

As the policy of CMHCs was not successful in the USA, this study will try to show why, or if, it could succeed in Korea. One element of the collapse of the system in the USA was finance. The parallel of economic crisis therefore raises a question for the success (or otherwise) of the model in Korea. This study attempts to demonstrate this. Also the study will look at the 'Confucian Welfare State' alongside these other 'western' arguments such as Scull's work on decarceration. Also this study will consider the extent to which the Korean government is truly Confucianist or whether it embraces Confucianism in certain policy areas because it suits them to do so in terms of benefits to the state in that the Korean government has adopted a policy which has failed in the USA.

1.3. Research Questions and Objectives of the Study

The purpose of this study is to analyse Korean mental health policy making. In other words, investigate how and why the mental health policy has been developed in Korea. In recent years, both the nature of and priorities for mental health policy have undergone important changes in Korea. There have been some questions about these changes:

1. How has this come about, and what are the essential elements of contemporary policy and practice?
2. What forms of policy and practice have emerged in mental health care and what types of knowledge inform this?
3. What organisational changes, policy directions, and economic and social developments have contributed to the development of mental health services in Korea?

In order to find answers to these questions, the aims of this study are as follows:

1. To examine how the nature of mental health policy is related to the changing rationalities and technologies of government in Korea.
2. To explore the way in which rapid structural changes (such as economic development, urbanisation and other demographic factors, and the economic crisis of 1997) have raised issues that are seen to require a social policy response in Korea.

3. To examine the extent to which the decisions about policy responses to perceived social problems are structurally driven or the extent to which they are informed and shaped by Korean politics and culture.
4. To explore the policy responses to perceived social problems including the increasing number of people with mental health problems and the way in which other social problems are individualised within families and whether these policies are informed and shaped by Korean politics and culture.

Its aim is to enhance our understanding of contemporary practice of governance by focusing on the analysis of a particular problem: mental health problems. To this end, the objectives of this study are as follows:

1. To clarify the policy direction which was the primary influence on mental health policy making.
2. To examine actual welfare development in Korea which is perhaps best explored, first, by examining the period leading up to the economic crisis in 1997, and second, by examining the period following that crisis.
3. To explore the structural and cultural factors in Korea commencing with the background of the historical development of social policy and the evolution of mental health policy.
4. To explore the changing role of the state in providing mental health care services for those with mental health problems during the industrialisation period.
5. To examine the relationship between the economic situation in the aftermath of the economic crisis of 1997 and social policy making.
6. To explore the policy responses to mental health problems and examine the way in

which caring for people with mental health problems was individualised within families prior to the economic crisis of 1997.

1.4. Research Methods

This study is an analytic case study that is both theoretical and practical, providing the rules for the formation of statements and the changing rules and priorities of day-to-day practice in the mental health care arena. In addition, through this study the nature of mental health policy is related to the changing rationalities and technologies of government. Archival data were used extensively in this research. Interviews conducted informally were used to enhance the reliability and validity of archival data.

This study is also framed by theoretical orientations and expectations derived from past comparative historical work on mental health and social policy involving both qualitative and quantitative research. The interpretation and causal analysis of a particular history would not be possible without such an empirically informed theoretical framework, as there is no way to examine a case without guiding ideas (Ruschemeyer and Stephens, 1997; Rueschmuyer et al., 1992). Essentially, an appropriate conceptualisation, that is, a historically grounded definition of a case, is an important part of the whole research project with 'theoretical, substantive, and historical' interest with which case-oriented and historically oriented studies are associated (Ragin, 1997; Skocpol, 1984).

It is said that analytic case studies have value in that they throw light on a particular

history, that is, its own particularity and diversity against general trends (Ragin and Zaret, 1983). As Rueschemeyer et al. (1992, p.32) point out, 'case centred research can examine the particular context of seemingly simple facts and take into account that their analytic meaning often depends on the historical context.' Not only is a historical analysis essential for a meaningful understanding, but it is also crucial for a causal analysis because many present-day social patterns and institutions have deep and, often, well-hidden historical roots. The past persists throughout history because once social patterns are established, they are highly resistant to change (Rueschemeyer and Stephens, 1997). Equally important, a historical analysis pays attention to the sequencing of historical events or conditions, which helps to figure out whether a different sequencing matters in producing a present outcome. Even a single case study has a great potential to contribute to a causal analysis if its theoretical expectations are specific enough with 'comparative awareness and especially a longer time span of investigation' (Rueschemeyer et al. 1992, p.33).

The use of case studies has proved an attractive way of illustrating and conveying the rich detail of various kinds of events. It allows a more in-depth analysis of a chosen case. Case studies can throw an important light on political processes and such processes are significant determinants of policy designs (Colin, 1993; Rubin and Babbie, 1993).

One of the concerns of this study is to understand how social changes have affected the course of social welfare development in general and mental health policy and practice in particular in Korea. This study will examine the major forces leading to the development of Korean mental health policy and practice since the 1960s as a case study. In identifying the forces that have influenced welfare policy development in

Korea, the study can begin by looking at structural and cultural influences that could, theoretically, have played a prominent role in this process.

As noted before, this study is a single-case study on state intervention in Korea in mental health care since the late 1960s. To make clear the research methods of this study, let me start with two related issues: the use of an historical approach in policy studies and the validity of a single-case study. According to Skocpol (1984, pp.362-386), there have been three major research strategies which have brought history into theoretical ideas: 'applying a general model to history, using concepts to interpret history and analysing causal regularities in history'. Each of these strategies may be applied to a single historical case or to two or more cases through comparative historical investigations. To classify this study in terms of Skocpol's, it is a single case study adopting interpretative research strategy. Historically-oriented interpretative research is a type of empirical study in the way that it attempts to account for specific historical outcomes or processes chosen for study because of 'their significance for current institutional arrangements or for social life in general' (Ragin 1987, p.3). Thus, this study primarily involves meaningful interpretations of broad historical patterns with respect to state intervention in Korea since the 1960s.

For the purposes of the analysis, this study will consider the industrialisation era in terms of historical periods: from the early 1970s to the early 1990s, from the early 1990s to the mid-1990s, and from the mid-1990s to present. In order to achieve these objectives, this study deals with the dynamic process of state intervention in mental health policy in Korea since the early 1960s, when the state started to pursue industrialisation according to the Economic Development Plan. Thus, the time span is

four decades, including five political regimes: the Park Chung Hee regime (1961-1979); the Chun Doo Whan regime (1980-1987); the Rho Tae Woo regime (1988-1992); the Kim Young Sam regime (1993-1997); and the Kim Dae Jung regime (1998-present). This study will examine how the different institutions of the family, the market and the State have been co-ordinated and balanced and how this has changed across the four periods. Although the study will be concerned with the shifting balance between the three institutions, particular attention to the changing role of the state will be given. This is not because the state plays a primary role in providing welfare, certainly not in mental health care where the family is central, but because the State is the crucial organiser in establishing the mix, relationships and boundaries between the institutions. It is therefore important to identify the political decisions, settlements and changes which have shaped and modified the balance and composition of the three institutions. This study is particularly concerned to make explicit embedded assumptions, often unstated, about the role of the family, the position of those with mental health problems and the nature of social citizenship, all of which are key to understanding the changing nature and role of mental health policy and practice.

However, one would raise a question with respect to the validity of interpretative historical approach applied to a single case in that it would have the risk of plunging into anecdote or historical narrative. In particular, from the perspective of those concerned with universally applicable deductive theory, any studies choosing 'historical interpretations can be criticised as being non-theoretical, since they have been motivated by substantive issues rather than a theoretical programme' (Immergut 1998, p.27). The danger is probably greater for single case studies, since they are not concerned with 'establishing explanations that hold well across other countries'

(Skocpol 1984, p.372). The researchers therefore have to be very cautious in doing research design with interpretative historical approach. To avoid the risk, the following research strategies will be applied.

First, as Ragin points out, the most valuable feature of the case-oriented approach is the fact that it engendered an extensive dialogue between the investigator's ideas (theory) and the data (evidence) (1987, p.49). This feature is also a crucial aspect of the historical approach. In order to produce historically interpretative, causally analytical explanations, the investigator needs to pay attention to matters of conceptual clarification and apply explicit concepts to the study. Hence this study will put forward the concept of 'governmentality', which has been developed by Foucault, and then use this concept to examine the causes, patterns and consequences of state intervention in mental health policy and practice over time. This study also draws on Foucault's work (the genealogy of modern forms of governance) to develop an analysis of the forms of reasoning and acting that underpin and articulate the governance of mental health problems by examining the case of Korean mental health policy. It is deductive in the way that these theoretical concepts serve as guides in the examination of causally relevant patterns in the policy changes. Thus, this study is not only aimed at historically interpretative investigation; it also seeks to develop causally analytic explanations that would contribute to stimulating the development of substantive theories. This study also provides a substantive analysis of contemporary governance of mental health problems.

In order to analyse mental health policy making in Korea, this study will draw heavily on recent Foucaultian work on 'governmentality' (see Chapter 4). This concept will be useful in such a context because of the innovative ways in which it helps us to describe

‘the amalgamation of an array of governmental technologies (methods of intervening in the non-discursive world constructed by political rationalities) that work across private and public boundaries to realise, or at least attempt to realise, governmental programmes’ (Rose 1993, p.286). By this means it is possible to understand that the emergence in Korea of a specific governmental interest in mental health policy is characterised by certain reproductive regularities and capacities which are amenable and open to intervention. A brief genealogical approach will provide an opportunity to trace the threads of a concern with mental health policy making, its amalgamation with other governmental technologies and forms of reasoning, and its eventual deployment within the context of mental health policy making.

In this connection, it could be argued that we need to understand governmentality in a number of distinct ways. This study proposes here to examine the application of governmentality in problematising mental health policy making in a Korean context from three fronts. First, the concept of governmentality will be used as a particular method or way of understanding the ‘conduct of conduct – a form of activity aiming to shape, guide or affect the conduct of some person or persons’ (Burchell, Gordon, and Miller 1991, p.2). Second, using the conceptual framework of ‘governmentality’, it could be argued that one of the most important aspects of this shift is that neo-liberal forms of social policy governance re-code and re-problematise the function of the mental health care system, predominantly in terms of an economics discourse. Finally, the government’s rationale for fostering ‘Confucianism’ will be examined in order to look at the moral discourse on the family. This does appear to have been useful in legitimating their suppression of demands for welfare programmes.

It could be argued that adopting an historical approach has a number of advantages. First, it provides a comparative base. Second, by considering change over time, it is possible to identify specific forces and the role they play in the construction of mental health policy and practice. Third, there is some degree of continuity¹ in mental health policy (e.g. Confucian influences) over time.

This study retraces the preconditions of mental health policy development and its associated socio-cultural background. Also the study will illustrate how social order determined the patterns of mental health policy, which offer a new path to travel to this different cultural world. Taking the Confucian Korean state into its frame of reference, it will consider how mental health policy types are intertwined with specific cultural norms (see Chapter 4), family institutions (also see Chapter 4) and models of social policy (see Chapter 5 and 6).

Also, the development of mental health policy in Korea, as elsewhere, can not be considered in isolation from wider economic and socio-political developments. Therefore, for a better understanding of the dynamics that have driven the development of mental health policy, wider economic and socio-political developments need to be presented. It is believed here that without an examination of the environment in which the current policy is formulated, any study of the policy would be incomplete. The

¹ In effect, social life in Korea is affected by Confucianism; therefore, politics has a strong Confucian tint. Leaders are depicted as patriarchal figures and the state is ideally seen as the extreme extension of one's family (Kim Kwang-ok 1988, p10). A "true" Confucianist would probably say that state ideologies in Korea are distorted Confucianism. Confucianism has been reformed, reinterpreted, revitalized or distorted (according to one's preference) several times in its long existence as a political and philosophy in Korea. Moreover, Confucianism is not a pure creed, uncontaminated by other ideas and beliefs. However, the fact remains that political leaders in Korea, in their efforts to mould the population ideologically in each of their respective territories, rely on ideas and formulations found in the Confucian classics and transmitted to each new generation in the processes of socialization and education.

examination of the current environment, however, can only be complete if its historical development is satisfactorily grasped. This study intends to address the general task by presenting detailed accounts of (a) the general economic and socio-political developments throughout the history of Korea with special reference to developments in mental health care, and (b) the development of Korean mental health policy in the same period. Moreover, in order to put the analysis of mental health policy in perspective and to make it easier to place the current policy initiatives, it seems necessary to introduce the mental health status and mental health care system of the country.

In this regard, it is necessary to examine how these processes operate in socially and historically specific situations, and how the development of particular institutional arrangements, which are themselves shaped by a range of social forces, affect the processes of policy shift towards community-based mental health care in Korea (Busfield 1996, p.191).

Second, the historical approach attempts to account for 'significant historical outcomes or processes by piecing evidence together in a manner sensitive to historical chronology and by offering limited historical generalisation which are sensitive to context' (Ragin 1987, p3). Thus, the choice and use of historical evidence is crucial for doing the research. There are a wide variety of documentary sources at our disposal for the research, but we should pay attention to particular materials due to the limited time available. Scott suggests four criteria that can be taken into account in assessing the quality of the historical materials: 'authenticity, credibility, representativeness and meaning' (Scott 1990, p.6). Bearing these criteria in mind, primary sources for this study are collected from government documents, official statistics, legislation and

reports and comments in magazines and newspapers. The fieldwork for the primary sources has been done mainly in the National Assembly Library in Korea, the British Library and several internet web-sites of the Korean government or private organisations. Secondary sources, including books, journals, working papers, and Ph.D. dissertations have been collected from the National Assembly Library in Korea, the Library of the University of Nottingham, and through interlibrary loans.

Archival data are used extensively in this research. A great number of previous studies that analysed the social policy-making process in Korea are utilised as historical documents. More specifically, this research employs these studies as a reference to the social policy-making process in Korea. In particular, *the White Paper of Health and Social Welfare Yearbook* (1962-1994) published by the Ministry of Health and Social Affairs, and *the White Paper of Health and Welfare Yearbook* (1995-2003) published by the Ministry of Health and Welfare are a rich informational source for understanding the development of mental health policy from the 1960s to the present. These publications were released specifically as a historical document that records the development of major social welfare programmes in Korea, and it is upon this that this study largely focuses.

Numerous research reports by mental health policy experts as well as much scholarly work was adequately examined to extend the understanding of mental health policy-making in Korea. Their analytic viewpoints and accurate description of mental health policy development in Korea furnished rich information.

Newspapers, magazines, and government and international statistics offer social,

political, and economic facts related to mental health policy development in Korea. Newspapers and magazines also provide several valuable interviews used for the analysis.

Interviews are primarily used to enhance the reliability and validity of archival data. Interviews were informally conducted (see Appendix II). Interviewees recommended reliable informational sources and enabled me to be aware of current issues. They deepened my understanding of mental health policy and services and the mental health policy making process in Korea. Their major role in my study is to confirm and clarify information drawn from the primary and secondary literature.

Interviewees include the following: Researcher in Korea Institute of Health and Social Affairs (Soh, Tongwoo), Psychiatrists (Kim, Jinhak and Lee, Hoyoung), Nurse (Kim, Suzy), Mental Health Social Worker (Yoo, Soohyun), Social Work Expert (Park, Jongsam), Social Rehabilitation Centre Worker (Lee, Bongwon), and Civil Servant (Park, Soochun) (see Appendix I).

My initial fieldwork took place in April-June 2000; additional fieldwork was undertaken in December 2000 - February 2001 in Seoul, the capital of Korea. During these two periods, archival data, primarily at the National Assembly Library and the National Library of Korea, were examined and collected. Interviews were conducted during both trips.

Finally, given the fact that many theories on the development of mental health policy have emerged from studies of single nation cases, such as Rogers and Pilgrim (2001) on

mental health policy in Britain, Rochefort (1997) U.S. mental health care policy analysis, Samele (1993) Italian psychiatric care, to name but three, there is no reason to reject the single-case study as a compelling approach to lead substantive theories of mental health development. However, as Castles (1989) points out, we should bear in mind that comparison makes possible a simultaneous focus on both similarity and difference, so that the antinomy of national uniqueness and general trends can be analysed and resolved in terms of variations on a common theme (Castles 1989, p.4). Comparison may be essential to highlighting the distinct features of each individual case. In this respect, this study will use comparisons of Korea with other countries, where possible, as an auxiliary research method. Comparisons in this research will be concerned with quantitative data on health and welfare related to mental health care inputs and outcomes that are readily available. This cross-national comparison will provide an opportunity to find out both similarities and differences with regard to the provision of mental health care in Korea.

1.5. Organisation of the Thesis

This study attempts to find structural and cultural influences in mental health policy making in Korea. For this purpose, first of all, the study identifies the characteristics of the development of Western mental health policy and practice. Also this research analyses the policy direction during the industrialisation period and in the aftermath of the economic crisis of 1997, and how the policy direction affected mental health policy making.

This study consists of nine chapters. In Chapter 1, the purpose of the study is presented, including the research questions, and research method.

Chapter 2 explains the political, cultural and socio-economic foundations which have affected Korean social policy development, and explores the emergence of state welfare. Special attention will be focused on a fundamental question: 'Have the special circumstances of the country exerted an influence on the evolution of its social policy?'

Chapter 3 reviews the literature and arguments that explore the factors affecting mental health policy making in Western European and North American countries (especially the U.K. and the U.S.). Chapter three also tries to examine theoretical perspectives for mental health policy development and explores the relevant theoretical framework for Korean mental health policy making

Chapter 4 focuses on the conceptual framework, governmentality. Chapter Four deals with the literature and arguments that explore cultural influences on policy making in order to understand Korean mental health policies. The cultural explanation is more likely to be important to understanding Korean social policies including mental health policies because the division of welfare in Korea developed out of a unique set of historical and cultural circumstances.

Chapter 5 and 6 deal with the contemporary discussion about industrialisation and urbanisation (main structural factors) as well as Confucianism and Westernisation (the main cultural factors). The reflection on the need for welfare as a means or aid to managing social change is then discussed. The thrust of this chapter is on the policy

responses to some perceived social problems and the way in which other social problems are individualised within families. These policies are informed and shaped by Korean politics and culture. In order to clarify the policy direction which was primarily influenced by mental health policy making, actual welfare development in Korea is explored. First, through the period leading up to the economic crisis in 1997 (Chapter 5), and second, by examining the period following that crisis (Chapter 6).

The thrust of Chapter 7 is on policy responses to perceived social problems related to mental health (i.e. the increasing number of people with mental health problems) and the way in which the problems of mental health were individualised within families. The mental health policies during the industrialisation period were informed and shaped by a strong Korean cultural tradition and repeated affirmation of the values and practice of Confucianism.

Chapter 8 examines the relationship between the economic situation and mental health policy making in Korea. What does mental health policy look like now and how does it fit with broader policies (e.g. the productive welfare approach)? The thrust of this chapter is on policy responses to perceived social problems related to mental health (i.e. the increasing number of people with mental health problems) along with the inauguration of a relatively progressive government in Korea in the aftermath of the economic crisis. The mental health policies during the economic crisis were informed and shaped by repeated affirmation of the values and practice of Confucianism.

Finally, Chapter 9 reviews the findings and insights gleaned from this study's analyses, and discusses the relevance and utility of its topics. This chapter also considers the

scope and generalisability of this study's findings. In the second section, the study's insights and contributions to mental health policy development and policy making are examined. This second section also highlights the contribution the findings make to the body of policy development and policy making in the mental health arena.

Chapter 2. Background of Social Policy in Korea: Structural and Cultural Influences

It could be argued that the study of social policy originated in the west, in the nineteenth century, in reaction to the enormous social changes brought about by the industrial revolution (Manning, 1985). Society and Government became aware of social 'problems' which either posed a challenge to the social and political order or which offended a group of people for humanitarian reasons. In particular these problems were seen to be susceptible to change through collective social action. In Western Europe, the period of change from initial industrialisation to the formation of developed welfare regimes took some 200 years. By contrast, the industrialisation of Korea commenced only around 40 years ago. Social policy has consequently only recently come to the fore as a response to perceived social problems. Welfare policy has begun to emerge as a result. But how did this policy develop and how were the responses formulated?

There are traditionally two main ways of accounting for policy development - politically and structurally. The political approach suggests that cultural diffusion and policy learning spread through personal contact and a growing shared knowledge. This has been dubbed the school of 'politics matter' (Castles, 1982). The suggestion is that policies are less a rational response to problems than a site for argument, contest and struggle. Rhodes and Marsh (1992) have refined this in terms of policy networks, and on occasion, more substantial policy communities through which policies are developed and refined and in which bureaucracies are seen as political rather than technical.

Resources are struggled over and positions established and defended. Extreme versions of this can appear where a model is imposed for political (or religious) reasons.

The structural approach, on the other hand, suggests that countries have shared structural and economic problems that dictate periods of convergent policy responses to convergent or parallel problems. For example, Heclo (1974) argued that social security systems evolved through a process of trial and error as bureaucracies learned what worked and what did not, more in the style of Lindblom's 'muddling through' (1980) than rational decision-making. Nevertheless, policy development here is seen as a cumulative adjustment to reality. Wilensky (1975) famously argued that a nation's social welfare 'effort' was determined by economic growth and its 'democratic and bureaucratic consequences', in particular, by the growing proportion of older people and the meeting of their needs. In reality, of course, we expect to find a mixture of both processes, and there have been attempts to combine political and structural factors in a 'shared framework', for example, by Hage *et al* (1989) and Hicks and Swank (1984), though none of these have really been successful. .

Social policies are influenced by political, demographic and economic factors and are created by the interplay of these factors. To investigate the development of mental health policy and to explore the driving force in shaping mental health policy in Korea, an understanding is needed of the processes by which social policies in Korea are made and the political and economic contexts in which policy decisions are taken. However, the development of social policy in developing countries is different from that in the developed world (Chow, 1987; Walker and Wong, 1996; Goodman and Peng, 1995; White *et al.*, 1997; Kwon, 1998). In short, in confronting social problems, the same

solutions may not be applicable for every country and the consequences may not be the same for every country. It also means that the Korean social policy needs to be situated in the Korean context, which has been formed by various specific cultural values embedded in individual lives, patterns of interactions among individuals, the family, the community and the state. These factors, and the resulting situations might be very different from those with Western experience of social policy development. Thus, to understand the nature of Korean social policy development, it is essential to explore the internal and external variables which have influenced Korean development.

This chapter explains the political, cultural and socio-economic foundations which have affected Korean social policy development and explores the emergence of state welfare. Special attention will be focused on a fundamental question: Have the special circumstances of the country exerted an influence on the evolution of its social policy?

The chapter is divided into four sections including the summary. The first section outlines a brief overview of the political factors in Korea since the 1960s. In section two, the relationship between the economic crisis and emergence of welfare provision during industrialisation is examined and the relationship between the changing economic situation and welfare reform is explored. Section three examines the cultural influences in social policy making. Based on this exposition, the implications of structural and cultural influence in Korean social policy are provided in order to understand mental health policy making in Korea.

2.1. Political Factors

Korea's industrialisation accelerated from the early 1960s. Late industrialisation coincided with the emergence of a strong authoritarian developmental state¹ in Korea. The Korean developmental state fostered economic growth vigorously while preventing the workers from participation and consumption. The prevailing image of the state has been that it ought to stand above and over the private sectors. However, the recent experience of democratisation clearly shows that the degree of state autonomy and elite cohesion has seriously deteriorated.² Furthermore, in recent years, Korea has witnessed eruptions of discontent from the conglomerates, not to mention labour conflicts. Consequently, such an accumulated discontent caused the battle for political liberalisation in the 1990s, leading to genuine democratic reforms. In this context, the policy-making process can be analysed in two different periods in Korea: periods of economic growth under an authoritarian regime (1962-1987) and the transition to democracy (1987- present).

There have been some recent studies on social policy in Korea (Joo, 1999; Kwon, 1999; Lee, 1999; Shin, 2000a, 2000b). They attempt to explore the 'dynamics of social policy change', 'social policy development', and 'globalisation and the emerging welfare state'. Through these studies, it has been found that there are some crucial periods in the development of social policy in Korea. They are divided into three periods for a better understanding of the policy-making process in Korea. For instance, the first is the

¹ See Charlmers Johnson, 1987; Charlmers Johnson's expression (1987), the '*Authoritarian Development State*' (ADS)

² The role of social policy experts was drastically reduced in the new institutional configuration. Previously they had been strategically located at the side of a president who enjoyed a monopoly over power, but as this shrank the role of the experts shrank accordingly. They also lost the political institution provided by the president and became subject to scrutiny (Kwon, 1999).

period of the 'authoritarian regime (1961-87)', the second the period of 'democratic participation (1987-present)'.

2.1.1. Authoritarian Regime (1961-1987)

A student uprising in 1960 brought about the demise of the 12-year rule of the First Republic. This was followed by the democratic parliamentary government of Chang Myon, which lasted only nine months. It was toppled by a coup led by General Park Chung Hee on 16 May 1961 (Baker, 1982). From this day through to 1987, when parliamentary democracy was inaugurated once again, three authoritarian military regimes seized power: from 1962 to 1971 the Third Republic of Park Chung Hee; from 1973 to 1979 the 'Yushin'³ Regime of 'Park'; and from 1980 to 1987 the Fifth Republic of Chun Doo Hwan. They ran an authoritarian regime under 'a façade of democracy and constitutionalism' (Lee 1999, p.26). All three regimes shared the characteristics of, to use Charlmers Johnson's expression (1987), the 'Authoritarian Development State' (ADS), and the welfare state responses of each regime were not identical but common in their basic premise that welfare state policies should remain minimal and able to be utilised as political instruments for authoritarian developmental rule.

As mentioned above, the Third Republic opted for outward-looking economic development policies, implemented a series of Five-Year Economic Development

³ Under the Yushin regime, the president had sweeping powers to rule by decree and used them aggressively to control political activity. For example, criticism of the Constitution itself was made a punishable offense. The legislature and the political parties represented in it were narrowly circumscribed, and although debate within the legislative hall was supposedly protected, it often was not reported to the public.

Plans⁴ and achieved remarkable economic success. The First Five-Year Economic Development Plan, launched in 1962, resulted in an average annual real growth rate of 7.9 per cent. It was followed by the Second Five-Year Plan which achieved an average growth rate of 9.6 per cent a year. The Third Five-Year Plan (1972-1976) reached 9.2 per cent, and the Fourth (1977-1981) 5.8 per cent, despite minus growth in 1980. The Fifth Five-Year Plan (1982-1986) achieved a 9.8 per cent average growth rate and the Sixth (1987-1991) continued the high growth rate at a 9.9 per cent average. During the 25-year period between 1962 and 1987, the Korean economy grew at an average rate of 8.9 per cent per year. The per capita GNP for 1960 was only US\$80, one of the lowest in the world. It rose to US\$252 in 1970 and to US\$3,218 in 1987. This rapid economic growth contributed to an overall rise in the standard of living for the general population and altered the composition of its industrial structure. In 1961 the primary sector accounted for 79 per cent of the Korean labour force, but in 1988 70% of the labour force was employed in the secondary and tertiary sectors. 'Korea had, in a very short space of time, transformed itself from a predominately agrarian society into an industrial one' (Lee 1999, p.26).

Many attempts have been made to account for this remarkable sustained economic growth. The factor most often referred to as contributory was the role of the state, which was determined to pursue outward-looking intentional economic growth. Park's quest for prolonged rule ushered in the Fourth Republic with the '*Yushin*' (restoration) system, which allowed Park to remain in power for life. The general political ideology was reorganised into a basically neo-Confucian structure. The '*Yushin*' system was legitimised by the government's drive for heavy chemical industries (HCI) predicated

upon 'the twin purposes of developing the indigenous defence industries and restructuring the export composition in favour of more sophisticated and high added-value industrial goods' (Baker 1992, p.173). 'Yushin' started with the outright repression of labour. Workers' collective action and the labour movement were perceived as 'more threatening than any other social movement' as they could disrupt 'the whole national economy directly through work stoppage' (Lee 1999, pp.26-7).

In summary, the state elite of the Park and Chun regimes, suffering from a lack of political legitimacy, largely relied on and believed in success in economic management through eliciting support from the general public. Although they achieved remarkable economic success, they eventually failed to stabilise their regimes. These contrasting events can be called 'the paradox of economic success' because the main cause of the regimes' failure to secure their regimes was economic success itself (Joo 1999, p.405).

Kwon (1999) points out that there was little opportunity for actors such as political parties, trade unions, business organisations and other interest groups to challenge those in power and influence the decision-making process within the institutional arrangements set up by the authoritarian regime. He explains this factor in more detail.

First, the National Assembly was effectively controlled by the government through constitutional provisions that ensured a majority for the government party in the National Assembly, regardless of the number of votes won in the general election. Second, the right to organise social groups was effectively removed and official interest-group organisations were controlled by the government. Third, repressive measures were widely used, including martial law and presidential emergency measures (pp.28-9).

⁴ The U.S. authorities worked with the military government to stabilize the economy and then help finance the first Five-Year Plan for development (1962-1966).

Another important point in gaining an understanding of the policy-making process during the authoritarian rule is the state elites' response to social problems. The state elites means those mostly at the top of the executive branch of the state institutions that determine and implement state policies and regulations concerning collective goods and state resources. More specifically, the term includes: 'the president, his top entourage such as the chief secretary; the heads of the intelligence and security services; the cabinet ministers; and the executive members of the governing parties during the authoritarian regimes of Park (1961-79) and Chun (1980-87)' (Joo 1999, p.58).

2.1.2. Democratic Participation (1988-present)

While the Korean economy has been on an extraordinary rapid growth trajectory since the early 1960s, Korean democracy has travelled a rocky road. Its political institutions suffered from authoritarian rule, so Korea's economic and political development has been 'severely disjointed and lopsided' (Cho 1994, p.16). However, successful economic growth unleashed social changes that ultimately overwhelmed the authoritarian state and, in 1987, Korea crossed 'a historic political watershed into parliamentary democracy' (Lee 1999, p.29). The march of democratic transition had commenced, albeit not at the pace and scope the public had anticipated during the height of the democracy movement (Im, 1989).

Chun's sponsorship of Korean nationalism in the form of the Asian Games of 1986 and the Seoul Olympics of 1988 proved to be 'a great challenge, opening a window of

opportunity for protest action' (Johnson 1987, p.13). After a spell of the most turbulent eruption of popular cries for more democratisation, more human rights, greater equity in income distribution and social justice, Chun was driven to make concessions, culminating in the Declaration for Democracy by Roh Tae Woo in June 1987 (Han 1988). The Declaration included fair and direct presidential elections as well as the release of political prisoners. Thus the Sixth Republic was ushered in, and parliamentary democracy was reinaugurated (Lee, 1999).

In January 1990, three political parties (headed respectively by Roh Tae Woo, Kim Young Sam and Kim Jong Pil) announced their merger, making the New Democratic Liberal Party (DLP) the largest political party in Korea. The merger was called the Grand Conservative Coalition and represented the interests of big business, which had been demanding more state support and less state control (Lee, H. Y., 1992).

Many Koreans consider the 1992 presidential election, which was won by Kim Young Sam of the DLP, to be first real democratic election as all three presidential candidates were civilian.

There were some changes in the policy-making process after democratic participation. Kwon (1999) notes that the new democratic arrangements brought about changes in general policy making:

First, the decision making process moved away from the confined institutional terrain in which the president had dominated all decisions and become more open; the National Assemble continued to play a greater part in policy making; and the factions within the governing party gained a strong voice on political issues. Second, the new emergence of several effective points of decision

making meant that there were more access channels for interest groups. However they were slow to take full advantage of the new institutional arrangements and it would take time for them to adapt their strategic and organisational structure to the new environment. Third, the role of social policy experts was drastically reduced in the new institutional configuration. Previously they had been strategically located at the side of a president who enjoyed a monopoly over power, but, as this shrank, the role of the experts shrank accordingly. They also lost the political institution provided by the president and became subject to scrutiny (Kwon 1999, pp.67-68)

2.1.3. The Implication of Political Factors for Social Policy

The political perspective has gained wide support among Korean scholars (Kwon, 1995; 1996; 1997; Joo, 1999). The state-centred perspective can be subdivided into two forms, the first of which can be referred to as the actor-centred approach and the second the institution-centred approach. The former focused on the political interests of the state elite and argued that the development of social policy in Korea was primarily determined by the politics of 'legitimacy' (Ha, 1989; Kwon, 1995). There is little doubt that the introduction of a social security programme was the result of government attempts to recapture the allegiance of disaffected blocs in society. On the other hand, other groups of scholars have focused on the configuration of the executive branch, especially between economic and social ministries, and argued that differences in this configuration in turn have varied consequences for social policy (Chung, M., 1993). It is true that the imbalance between economic and social ministries in terms of organisational power and capacity has brought about a limited development of social security in Korea.

In contrast the political conflict perspective derived from Marxism sees politics and power in class terms, the economy as a source of contradictions, exploitation and hence of collective conflict. Adopting a theoretical framework developed in the Neo-Marxist school, several scholars have argued that social policy in Korea developed as an instrument of social legitimation in the face of intensified contradictions in monopolistic capitalism (Research Group of Health and Social Affairs, 1989; Kim, R. H., 1989; Kim, Y. M., 1989). There is little doubt that they have contributed not only to undermining the modernisation thesis that had been dominating in social policy studies in Korea but also to understanding structural causes of social policy. Nevertheless, their explanations tend to be a priori reasoning, given that Korean capitalism works on the foundations of highly regulated labour markets and industrial structure, authoritarian employment practices, weak labour movements and the underdevelopment of the political party system, especially the absence of a left-wing party.

From these political perspectives, the government developed welfare systems in order to gain political legitimacy. Kwon (1995) argues that the development of the Korean welfare system has been determined primarily by the politics of legitimation, particularly during the period prior to democratisation. Welfare systems have been constructed by authoritarian regimes seeking to legitimate themselves; social welfare has only attracted the interest of policy-makers when they need to enhance their political support. Through case studies of the Medical Insurance Law and Minimum Wage Law, Joo (1999, p.387) also argues that the prime cause of social policy development in Korea was 'the interest of the state elites in political survival, and their concern with their reputation in international society, together with the residual role of the changes in environments and legacies of previous policies'.

Debates have also focused on the role of bureaucrats and social policy experts in policy making. Kwon (1995; 1997, pp.479-80) contends that 'bureaucrats and policy experts who were strongly motivated to take the nation forward and bring it up to the international standard of advanced countries, played a significant role in the introduction of social policy, despite the constraints of their political masters, who set limitations on policy making and changes in economic conditions'. Joo (1999, pp.406-7), however, has argued that 'this analysis emphasising the policy ideas of administrative elites in social policy development has little relevance to the Korean experience'. He stresses that the role of administrative elites is only significant after the core state elites have initiated the policy development process. Moreover, there have been relatively few influential policy experts in the welfare policy field in Korea. The most important factor in the development of social welfare in Korea has been the role of the elites in power rather than the mobilisation of the working class, who exerted political pressure through class-based political action in Western countries.

However, political explanations offer a partial picture with regard to the development of social policy in Korea. They still need a more comprehensive examination of the causes of social policy development. For a thorough examination of the development of social policy, other factors prompting policy development such as changes in both socio-economic structure and international markets, social coalitions, requirements of economic policy and policy legacies still need to be taken into account.

2.2. Socio-economic Factors

Since the 1960s Korea has experienced a remarkable economic growth. Along with the expansion of the economy, welfare services and programmes for the poor and vulnerable have also have been developed. Korea's 'economic miracle', however, was engineered by an authoritarian regime of the capitalist developmental state. The capitalist developmental state is characterised by a strong state that readily intervened in the market to influence the economy, a high degree of state autonomy vis-à-vis civil society, an efficient bureaucracy and an authoritarian regime and style of politics (Johnson, 1989). Korea was one of the world's economic miracles in the three decades until 1997, when the Asian crisis hit the country. Korea experienced a rapid fall in economic growth (and hence lowering of the quality of life), tumbling stock markets, rising unemployment and growing social inequalities.

2.2.1. Industrialisation: Economic Growth and the Emergence of Welfare

Korea experienced the most rapid and sustained economic development up to the late 1990s. This impressive performance followed the severe dislocation resulting from the division of the country in 1948 and the Korean War. Korea's phase of rapid growth only began in 1961 with the establishment of a new government committed to economic development, which emphasised an export-oriented development policy based on the expansion of exports, macroeconomic stability and investment in physical and human capital (OECD, 1996). In the 30 years up to 1997, the average annual GDP growth rate of 8.4 per cent was one of the highest in the world. Rapid economic growth resulted in a

marked improvement in living standards across all segments of the population. Real per capita income increased eight-fold between 1961 and 1992, reaching nearly \$7,000. The share of the population classified as living below the 'poverty line' declined from 40 per cent in 1965 to less than 10 per cent (OECD, 1994).

2.2.1.1. Economic Growth

Korea's economic growth up to 1997 was one of the most rapid in the world. With the success of a series of Five-Year Economic Development Plans, the Korean economy achieved continuous growth. Annual economic growth rates stood at around 9 per cent in the 1970s and 1980s, while the average annual growth rate between 1990 and 1995 was 7.2 per cent. Per capita GNP rose from US\$ 82 in 1960 to US\$ 10,548 in 1995 (see Table 2.1).

Table 2.1. The Economic Growth Rate

| | 1962 | 1970 | 1980 | 1985 | 1990 | 1995 |
|------------------------|------|------|-------|-------|-------|--------|
| GNP (bn. \$) | 2.3 | 8.1 | 62.8 | 94.3 | 253.6 | 352.0 |
| Annual Growth Rate (%) | 2.2 | 2.2 | -2.7 | 6.5 | 9.5 | 8.9 |
| Per Capita GNP (\$) | 87 | 253 | 1,597 | 2,242 | 5,883 | 10,548 |

Source: Bank of Korea, National Accounts, each year.

During the 1970s and the early 1980s, Korea's development policies focused on the promotion of heavy and chemical industries. Hence, a significance change in the industrial structure occurred. In the 1960s, the agriculture and fisheries industry comprised 39.6 per cent of industries, the mining and manufacturing industry, 14.4 per

cent and the service industry, 46.0 per cent of the GDP. However, in 1995, the ratio of the agriculture and fisheries industry to the GDP was reduced to 6.6 per cent, while the mining and manufacturing industry increased to 27.2 per cent (see Table 2.2).

Table 2.2. Changes in Industrial Structure

(Unit: %)

| | 1960 | 1970 | 1980 | 1990 | 1995 | 1997 |
|--------------------------|------|------|------|------|------|------|
| Agricultural and Fishery | 39.6 | 29.7 | 16.0 | 8.7 | 6.6 | |
| Mining & Manufacturing | 14.4 | 19.7 | 26.9 | 29.8 | 27.2 | |
| Services | 46.0 | 50.6 | 57.1 | 61.5 | 66.2 | |

Source: Bank of Korea, National Accounts, each year.

In order to overcome the natural handicap of scarce natural resources and a relatively small domestic market, the Government of Korea has focused on an export-oriented development strategy. As a result, the percentage of exports to imports rose from 33.1 per cent of the GDP in 1970 to 55.0 per cent in 1995 (see Table 2.3). The high dependency on foreign markets makes Korean industries sensitive to foreign market trends. In addition there was a growth in the employment rate until 1997 due to the government strategy on export-oriented industry.

Table 2.3. Trends in Trade Volume

| | 1970 | 1980 | 1985 | 1990 | 1995 | 1997 |
|--------------------|------|------|------|-------|-------|------|
| Export (bn. \$, A) | 0.9 | 7.2 | 28.4 | 63.1 | 123.2 | |
| Import (bn. \$, B) | 1.8 | 21.5 | 26.5 | 66.1 | 127.9 | |
| GDP (bn. \$, C) | 8.1 | 62.8 | 94.3 | 253.6 | 456.5 | |
| A + B / C (%) | 33.1 | 45.7 | 58.2 | 50.9 | 55.0 | |

Source: Bank of Korea, National Accounts, each year.

2.2.1.2. Employment Growth

Although Korea is one of the most densely populated countries in the world, it lacks economically essential natural resources. Such limited conditions underline the significant role of the nation's abundant human resources in its economic development over the last three decades. The massive pool of unemployed in the early 1960s and the subsequent rapid growth of the working age population of 15 years old and over further expanded the labour force. Although the annual growth rate of the total population gradually decelerated from 2.4 per cent between 1963 and the 1970s to less than 1 per cent in the first half of the 1990s, the working age population increased at a much higher rate than the total population over the entire period.

The growth rate of the working age population, which jumped from 2.6 per cent a year between 1963 and 1970 to 3.7 per cent in the 1970s, gradually declined to 1.7 per cent by the first half of the 1990s. This reflects the fact that most of the children born during the post-Korean war baby boom joined the working age population in the 1970s. The economically active population increased slightly more rapidly than the working age population prior to 1997, except for the first half of the 1980s when there was a gradual increase of women in the labour force.

Consequent to the labour surplus, the Korean government began to focus on expanding its labour-intensive exports because of the comparative advantage in view of its factor endowments. This strategy had a striking effect on creating jobs. During the period of rapid industrialisation (1963-1979), the annual average growth of total employment climbed to 3.7 per cent, and to 7.2 per cent in non-agricultural employment. Thus, the

national unemployment rate declined from 4.4 per cent in 1970 to 2.0 per cent in 1995 (see Table. 2.4).

Two critical changes occurred in the labour market during the latter half of the 1980s. First, the Korean labour market experienced a serious shortage in production jobs during the 1980s as it underwent a transition from labour surplus to a labour scarcity in the latter part of the decade, as reflected in the low unemployment rate of 2 to 3 per cent. The other change was the introduction of labour union activities. The labour-union law was enacted in 1953 and, even though there were considerable changes in the labour market, three core labour rights surrounding the right of labour disputes were restricted. This restriction persisted until democratisation was proclaimed in 1987. Following the 1987 proclamation, the activated labour union movements brought about a drastic increase in real wages, during some years even exceeding the increase in labour productivity.

Table 2.4. Population by Labour Force Status

(thousand persons, %)

| | Population 15 years and over* | Economically active population | | | Economically active participation rate | Unemployment rate |
|------|----------------------------------------|--------------------------------|----------|------------|-------------------------------------------------|----------------------|
| | | Total | Employed | Unemployed | | |
| 1970 | 17,468 | 10,062 | 9,617 | 445 | 57.6 | 4.4 |
| 1975 | 20,918 | 12,193 | 11,692 | 501 | 58.3 | 4.1 |
| 1980 | 24,463 | 14,431 | 13,683 | 748 | 59.0 | 5.2 |
| 1985 | 27,553 | 15,592 | 14,970 | 622 | 56.6 | 4.0 |
| 1990 | 30,887 | 18,539 | 18,085 | 454 | 60.0 | 2.4 |
| 1995 | 33,664 | 20,853 | 20,432 | 420 | 61.9 | 2.0 |

*Source: National Statistical Office

Table 2.5. Employed Persons by Industry

| | (thousand persons) | | |
|----------------------------------------------|--------------------|--------|--------|
| | 1985 | 1990 | 1995 |
| Total | 14,970 | 18,085 | 20,432 |
| Agriculture, forestry & fisheries | 3,733 | 3,237 | 2,534 |
| Mining & manufacturing | 3,659 | 4,990 | 4,824 |
| Manufacturing | 3,504 | 4,911 | 4,797 |
| Social overhead capital & other services | 7,578 | 9,858 | 13,074 |
| Construction | 911 | 1,346 | 1,905 |
| Wholesale and retail, hotels & restaurants | 3,377 | 3,935 | 5,378 |
| Electricity, transport, storage, finance* | 701 | 923 | 1,859 |
| Business, personal, public service & other** | 563 | 945 | 3,933 |

*Prior to 1991, transport, storage and communications

** Prior to 1991, finance, insurance, real estate and business services

Source: National Statistical Office

During the 1970s and the early 1980s, Korea's development policies focused on the promotion of heavy and chemical industries. Hence, a significant change in industrial structure occurred. In the 1960s, the agriculture and fisheries industry comprised 39.6 per cent of industries, the mining and manufacturing industry, 14.4 per cent and the service industry, 46.0 per cent of the GDP. However, in 1995, the ratio of the agriculture and fisheries industry to the GDP was reduced to 6.6 per cent, while the mining and manufacturing industry increased to 27.2 per cent (see Table 2.5)

2.2.1.3. Impact of Economic Growth on Korean Social Policy

Although industrialisation has produced a range of social problems, economic growth seemed to enable the Korean government to promote and expand its social welfare measures, including mental health care. Remarkable social improvements have occurred in Korea during the past few decades, particularly in its economy. Korea's economic

growth until the economic crisis of 1997 was one of the most rapid in the world. With the success of a series of five-year economic development plans, the Korean economy was continuous growth. The quality of life of Korean people has been considerably upgraded in many areas. The rapid economic improvement is reflected in the steady rise of the gross domestic product (GDP) per capita. This shows that Korean society is making economic progress, moving forward from a 'developing' to a 'developed' society, from an economic perspective. Since the mid- 1960s, rapid Korea economic progress made more social welfare programmes possible. There was increasing public demand and, due to the increase in Per Capita GNP capacity, the government could expand the scope of the welfare programmes, as there was the capacity within the tax-base.

2.2.2. Changing Economic Situation and Welfare Reform after the Economic Crisis

In December 1997 the Korean economy was on the brink of collapse and was bailed out by the International Monetary Fund (IMF). The IMF promised the much-needed help but with a string of conditions (Ministry of Finance, 1998). The economic crisis shocked the entire nation because Korea had experienced the most rapid and sustained economic development. The economic crisis had a considerable impact, not only on the Korean economy but also on social policy.

2.2.2.1. Economic Crisis of 1997

The negative impact of the financial crisis on the real economy became apparent throughout 1998. As Table 2.6 illustrates, GDP dropped 5.8 per cent year-on-year, reflecting an 8.2 per cent fall in domestic consumption expenditure and sluggish exports in the wake of the financial crisis. All industries showed negative annual growth and gross fixed capital formation also plunged 21.1 per cent in 1998. Consequently, per capita gross national income (GNI), which mirrors real purchasing power, also fell from \$10,307 in 1997 to \$6,823 in 1998.

Table 2.6. Major Economic Indicators 1995-1998 (at 1995 constant prices) year-to-year change

| | 1995 | 1996 | 1997 | 1998 | | | | |
|-----------------------------------|-------|-------|---------|---------|---------|---------|---------|---------|
| | | | | yearly | ¼ | ½ | ¾ | 4/4 |
| Exchange rate (won against \$) | 774.7 | 844.2 | 1,415.2 | 1,207.8 | 1,378.8 | 1,385.2 | 1,376.2 | 1,207.8 |
| Call Interest rates | 12.4 | 12.4 | 16.3 | 15.0 | 23.7 | 18.7 | 10.2 | 7.1 |
| Gross domestic Product (GDP) | 8.9 | 6.3 | 5.0 | -5.8 | -3.6 | -7.2 | -7.1 | -5.3 |
| Final consumption Expenditure | 8.2 | 7.2 | 3.2 | -8.2 | -8.4 | -9.7 | -8.9 | -5.8 |
| Private | 9.6 | 7.1 | 3.5 | -9.6 | -9.9 | -11.2 | -10.4 | -6.9 |
| Government | 0.8 | 8.2 | 1.5 | -0.1 | 1.3 | -0.7 | -0.6 | -0.4 |
| Gross fixed capital Formation | 11.9 | 7.3 | -2.2 | -21.2 | -20.6 | -23.7 | -22.2 | -17.9 |
| Exports of goods and Services | 24.6 | 11.2 | 21.4 | 13.3 | 25.7 | 13.2 | 8.0 | 8.8 |
| Imports of goods and Services | 22.4 | 14.2 | 3.2 | -22.0 | -27.2 | -25.5 | -25.9 | -9.0 |
| Gross national Income (GNI) | 8.1 | 4.8 | 2.1 | -7.9 | -6.8 | -9.7 | -8.6 | -6.6 |

*refer to at the last quarter of 1997.

Source: National Statistics Office, 1999

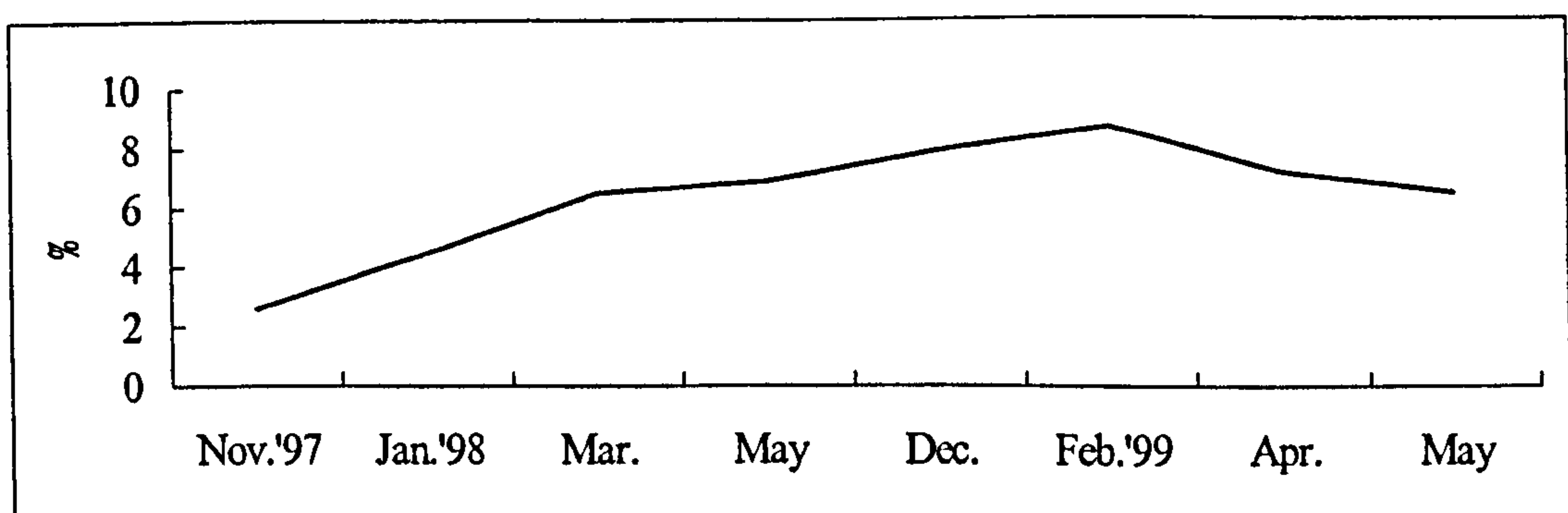
Such a deterioration of the real economy has had a great deal of negative impact on individual wellbeing. Nominal wages have fallen dramatically in the wake of the

financial crisis so that the year of 1998 witnessed a decrease in nominal wages for the first time since the 1960s. The sharp rise in import prices due to the depreciation of the won boosted consumer price inflation to 7.5 per cent during 1998. Consequently, real wages dropped by around 10 per cent at the end of 1998 compared to a year earlier. The average real annual income of the urban working class household was thus reduced by 6.6 per cent in 1998, compared to that of the previous year (National Statistical Office, 1999a). This decline in real wages, especially when combined with soaring unemployment, became a source of increasing economic hardship.

2.2.2.2. Increase in the Unemployment Rate

Figure 2.1 shows that unemployment rates increased dramatically after the financial crisis of 1997, transforming from a situation of near full employment to a level that threatens social stability. Before the financial crisis, unemployment rates in Korea were around 2.5 per cent, but they soared to 8.7 per cent in February 1999.

Figure 2.1. Trends of Unemployment Rates after the Financial Crisis



The number of jobless was listed at 1.8 million at that time. In particular, the unemployed who lost their jobs within the previous year exceeded 90 per cent of the total. In a country like Korea that, since industrialisation, has never ever suffered from high unemployment, such a soaring unemployment rate itself might have been enough of a threat to bring about social and political instability.

It is worth noting that this negative social impact has not been uniform across social groups. Table 2.7 shows that there have been some changes with respect to the composition of the unemployed in comparison to that before the financial crisis of 1997. First, if we look at the educational achievement of the unemployed, there has been a considerable increase in the proportion of the unemployed having a relatively poor education. Table 2.7 shows the number of the unemployed who graduated only from middle or primary schools increased by more than double in the wake of the crisis.

Second, the proportion of heads of household among the unemployed rose from 34.5 per cent in 1997 to 43.6 per cent in 1998, more than doubling in number from the year before. This caused hardship for dependants too. There was a number of suicides, called 'IMF suicides' by Koreans, referring to male bread-winners who were laid off and took their own lives and those of their dependants, presumably out of a belief that no one would be left to care for them (Koreaherald, 25 April 1998).

Third, middle-aged people had an increased risk of becoming unemployed. Table 2.7 illustrates that there was more than a doubling in the number of the unemployed among all middle-aged groups. In particular, those aged from 45 to 49 expanded more than

threefold. These figures suggest that people in this group are the main targets of structural adjustment in the labour market in the name of improving labour flexibility.

Table 2.7. The Characteristic of the Unemployed

| | 97 Jan.-Apr. | 98 Jan.-Apr. | Growth rate* |
|----------------------------|--------------|--------------|--------------|
| (%) | | | |
| Education attainment | | | |
| Middle school | 23.0 | 27.6 | 115.0 |
| High school | 54.8 | 52.5 | 71.8 |
| Technical college | 9.5 | 7.8 | 46.7 |
| University | 12.6 | 12.1 | 71.9 |
| Relations with householder | | | |
| Householder | 34.5 | 43.6 | 126.8 |
| Spouse | 15.8 | 16.0 | 80.8 |
| Others | 49.7 | 40.4 | 45.9 |
| Age structure | | | |
| 15-19 old | 8.1 | 7.1 | 58.8 |
| 20-24 old | 26.4 | 19.5 | 32.7 |
| 25-29 old | 21.1 | 19.1 | 62.4 |
| 30-34 old | 11.0 | 11.3 | 83.3 |
| 35-39 old | 10.8 | 12.5 | 109.2 |
| 40-44 old | 8.6 | 10.0 | 109.9 |
| 45-49 old | 4.6 | 7.9 | 214.1 |
| 50-54 old | 3.9 | 5.6 | 153.6 |
| 55-59 old | 3.0 | 3.9 | 133.2 |
| 60 or more | 2.7 | 3.1 | 107.9 |
| Previous Job | | | |
| Full-time employed | 26.0 | 22.3 | 125.5 |
| Temporary workers | 39.5 | 36.1 | 139.8 |
| Daily workers | 16.3 | 26.8 | 330.2 |
| Employers | 7.1 | 5.4 | 98.2 |
| Self-employed | 10.1 | 7.9 | 105.1 |
| Family-employed workers | 0.9 | 1.4 | 366.7 |

Source: Korea National Statistics Office, 1998.

Finally, there was a big increase in unemployment across all kinds of jobs. However, unstable wage earners, such as temporary workers or daily workers, formed the majority of the unemployed, accounting for 36.1 per cent and 26.8 per cent of total unemployed

respectively. In particular, the number of those whose previous job was that of a daily worker dramatically increased 4.3 times.

All these figures suggest that the social impact of the financial crisis was different across social groups. Temporary or daily workers who are middle-aged with a relatively poor education attainment were the worst affected. Furthermore, given that they were neither eligible for unemployment benefit nor living allowance as a form of social assistance benefits, the pain of the unemployed and their families was further aggravated.

As a result of the crisis, rising unemployment and the decrease of nominal wages destabilised households severely, and the poverty level rose both in absolute and relative terms while income disparities widened. While there has traditionally been a gap between urban and rural area wealth, new patterns of poverty emerged in the cities. The crisis brought a realisation that economic development cannot be socially sustainable without social policy measures. In this context, the government had to introduce a set of temporary measures as well as an important reform of the welfare system.

2.2.2.3. Impact of the Economic Crisis on Korean Social Policy

In the aftermath of the 1997 financial crisis, the severity of the social impact of the economic crisis was worsened by the under-development of social protection. The government, however, gave its priority to the strengthening of systems of social

protection. There appears to be a clear recognition that the design and implementation of structural adjustment programmes should be accompanied by social protection. The measures of the government included not only establishing a social safety net but also reforming the social security system (Shin, 2000a).

Moreover, households are likely to be more vulnerable than before in a globalising world with weaker traditional family support systems. A number of problems and concerns have emerged in the social policy arena since the economic crisis of 1997. The following are more likely to be considered by policy makers: deteriorating social integration; poverty in the outskirts of urban areas; inequality in the distribution of income and wealth; regional imbalance in the distribution of resources; weak rights and interests of the socially underprivileged; old age pension coverage for people who have not paid contributions; the high rate of unemployment; instability of employment; the protection of the needs of people (young, old, disabled) outside the labour market; the present system hindering self-support as a means to escape poverty; monopolistic tendencies in business-government collusion; globalisation and high labour costs.

The structure of Korean society is changing rapidly in the aftermath of economic crisis. Korea is becoming greyer, more urban, more formal, and more open both economically and politically. These trends have important implications for future social policies. Social policy cannot be divorced from the characteristic of the population and demographic changes will bring issues of old age security to the forefront and require changes in the patterns of public spending. Economic changes, driven by shifts in employment, greater urbanisation and continued globalisation, will be associated with greater labour mobility and increased political participation and will put social issues on

the political agenda. All three trends will put pressure on 'informal, family-based mechanisms for household protection and increase demands for more formal, government-mandated schemes' (Atinc 2000, p.142).

The social welfare system continues to be adapted to the economic market system. The government has attempted to pursue a strategy of moderate development in welfare provision in which the average level of provision, measured either by per capita social expenditure or its ratio to GDP, would be prevented from going to either of the two extremes, remaining instead on roughly the existing level. It is an important part of the government's social policy agenda to adjust the structure of welfare provision. To this end, the Korean government has attempted to seek a new social welfare system (see more detail in Chapter 6).

The Korean government has realised that, in existing welfare states, unemployment and income disparity are severe problems and excessive welfare expenditure threatens government finance, driving it towards a budget deficit crisis. Also the government is aware that over-generous welfare allowance has been criticised for diminishing welfare recipients' work incentive. In order to cope with these problems comprehensively, the government has attempted to find a new welfare model (see more detail in Chapter 6). In the establishment of a new welfare state model, several essential elements are to be considered: 'unemployment, income inequality, the financial crisis, stagnation and deteriorating work incentives' (Chung, K. B. 2001, p.1). To address these negative elements, more comprehensive policy planning needs to occur.

2.2.3. The Implication of Socio-economic Factors for Social Policy

In the case of Korea it could be argued that social policies, including mental health policies, have been subordinated by economic policies. Shin (2000b) argues that economic and social policies have not been determined in isolation from each other. He also points out that the form and content of social policy has been greatly constrained by the requirements of economic policy.

Since the early 1960s the Korean government chose the strategy of minimising labour costs for competitiveness in the world trade markets, which has subsequently had an important effect on shaping social policy. Social policy in Korea has been embedded in and constrained by the requirements of economic policy. Yet, the nature of policy linkages between economic and social policies varies according to the area of social policy and the content of economic policy (Shin 2000b, p.i)

As Kwon (1999b) points out during the period 1961-87 the governments of Korea pursued a strategy that can be summarised as legitimisation through economic performance. For instance President Park's government pursued an 'economic growth strategy' whereas President Chun aimed at 'economic stabilisation'. Consequently, economic policy took precedence over all other policy considerations, including social policy. This economic first strategy has also been witnessed in the Kim Dae Jung administration (1998-present) in the aftermath of economic crisis. It is called the economic recovery strategy.

In this regard, it could be argued that the economic strategy constrained social policy decisions and the structure of mental health policy. Financial liberalisation introduces a serious risk of the destabilisation of the economy of Korea through a sudden outflow of

portfolio capital and other forms of 'hot money'. Financial bailouts are aimed primarily at protecting the investor's and creditor's interest and the associated conditionalities often add to the 'diswelfare' of the general population resulting from the crisis. Moreover, the resolution of the problem within the framework of financial openness increases the risk of recurrent crisis and diswelfare for the population and is likely to be followed by further bailouts. Thus a vicious cycle is set in motion. The consequences for systems of social protection are contradictory. On the one hand, the commodification of the economy increased insecurity, undermined existing forms of social protection and thus underlay the need for an adequate social safety net in an open globalised economy. On the other hand, the disruption of the economy, resource constraints and fiscal austerity, and the ideology of privatisation militate against building programmes of social welfare. How to manage this contradiction is an important problem of public policy societies (Mishra, 2001).

Changes of this kind reflect the changing socio-economic environment and the government's declared aims: to adapt the social welfare system to the new global capitalist market economic system, to stimulate economic efficiency in a marketising and globalising environment, and to maintain political stability by solving social problems such as urban unemployment and poverty, which are mainly caused by market reform and international competition.

However, the policy direction during a period of industrialisation and globalisation reveals that a capitalist state is able to manage the public welfare demands not only with little negative impact on its accumulation, but also to use social welfare as a means to

create more economic opportunities. The key issues are what strategies are used to meet societal demands and which institutions are expected to bear the costs.

In the case of Korea's social policy during the process of industrialisation and globalisation, the Korean family, which stresses family obligation, has been emphasised as the basic caring unit responsible for the long-term needs of people with mental health problems while public welfare provisions provide only limited assistance to preserve the family's welfare function. In this way, responsibility for meeting the needs of the vulnerable groups has been diverted to the family system. As a consequence, individual and family work ethics have been preserved, while the financial sector has been enhanced for achieving further accumulation.

2.3. Cultural Factors

Recently, there has been a growing concern with the cultural dimension in comparative cross-national social policy studies. As MacPerson and Midgley argue, 'any account of Third World social policy should pay attention to the institutionalised patterns of obligation and cultural practices that respond to the needs of dependent individuals and families' (MacPerson and Midgley 1987, p.137). Asian countries' cultural heritage and traditional values and beliefs, which are strikingly different from those of Western countries in many important ways, also have a great impact on the development of welfare policy in these countries. Such cultural factors, expressed at 'the level of national ideology and political power', as MacPherson and Midgley point out, 'are important for a proper understanding of the rest of the world' (MacPherson and Midgley

1987, p.138). To understand welfare policy development in Korea, it is important to identify Korean culture and the value placed on the nature of society and its members, and hence to examine the way this culture and those values are applied to social problems.

Traditionally, Buddhism and Confucianism have played important historical roles in the early cultural heritage of Korea (Choi, E., 1994). Korean's strong commitment to their family is rooted in concepts from Buddhism and Confucianism, and some people even think that the basic unit of the self among Koreans is not the individual, but the family (Lee, 1983). Some cultural factors are inherited but some parts are changing, therefore creating a new culture. In modern society, many factors that influence cultural change are increasing. These factors include 'complicated geographical migration and changes in the family life cycle' (McGoldrick 1993, p.357). Compared with other world religions, the uniqueness of Confucianism lies in the fact that its teachings always begin with the family. In fact, the family is the main pillar of Confucianism. 'Arguably there is no other religion, which can surpass Confucianism in terms of its family-orientedness' (Choi, J. 2000, p.6).

In this context, the family was the most important group for traditional Koreans. It is largely due to the influence of Confucianism, which emphasises familial relationship or kinship more than any other relationships. That is, Koreans' attachment to the family is overwhelmingly strong when compared to that of other cultures. 'Such family-centred worldviews and sentiments are still very powerful in contemporary Korea' (Choi, J. 2000, p.8). These will be described in greater detail in Chapter 4.

However, over the last four decades Korea has undergone remarkable socio-culture changes due to modernisation, industrialisation and globalisation. It is said that the collectivistic Korean society is now gradually becoming more westernised and individualistic.

Korea's traditional culture, including its religious heritage, was seriously undermined. Moreover, since the 1960s, within a single generation, Korea has been transformed from an agrarian to an industrialised urban society. The adoption not only of Western science and technology, but also Western culture, has played a decisive role in bringing about this transformation. Swept into the country on the tides of Westernisation, industrialisation, and economic development, Protestantism has taken root and expanded its reach (Park and Cho 1995, p.120).

Along with growing concern over the weakening traditional values of family obligation, there has been an increasing awareness of the need to re-emphasise traditional moral values and the importance of moral education (see Section 4.3.1.3), particularly education in filial piety and respect for parents (Sung 1990, 1992; Han, 1996).

2.3.1. The Effect of Confucianism

Not only material conditions but also the mental environment has a great influence on a person's way of thinking and acting. Korea is a country of long history and various thoughts – including Western thinking – which have served an important role in moulding the Korean culture. For nearly five hundred years, traditional Korea – the Chosun dynasty – was ruled by a monarchy which maintained a highly centralised, Confucian-oriented system. Thus, Confucianism is one of the most prominent factors that may act to shape Korean culture and its effect is still rooted deeply in Korea's life.

Traditionally Korea and Japan belong to a form of Ancient Chinese culture, but unlike Japan, which was geographically sufficiently isolated to prevent Chinese intervention, Korea is so near to China that there has long been a much closer relationship. China often intervened in Korea, and these circumstances restricted the independence of Korea's internal development. Thus, though both Korea and Japan were exposed to Chinese Confucianism, the effect is much greater in Korea.

2.3.1.1. Confucian Influence in Political Culture

It is said that the Korean political structure has been strongly influenced by Confucian tradition (Kihl, 1994). Confucianism is the foundation of social and political attitudes. Because hierarchy and authority are the main tenets of Confucian thought, they have penetrated the ideology of the ruling and administrative sectors of society. Accordingly, the Korean style of governmental bureaucracy has been notable for its strong and dominating leadership. It has remained a spontaneous by-product of this particular ideology within Korean society. Kim and Kim (1997) have defined two noteworthy factors by which Korean political culture has been affected: first, 'Confucian hierarchical subordination,' which implies a high sensitivity to authority-support in socio-political life; second, 'a high degree of cultural homogeneity,' which has tended to inhibit not only the fragmentation of power but also the diversification of group political interests (p.64). These two ideological norms contributed fundamentally to the formation of the political structure of Korean bureaucracy. Oh (1999) describes Confucian influence in Korea thus:

The key legacies of Confucianism in Korea were authoritarian, paternalistic, and family-centred, legacies that are visible in that country today. Most Koreans still look to their leader, the president, for key decisions and Korean chief executives have played extraordinarily defining roles in Korean politics and government. Family ties in Korea still constitute the central element in the lives of Koreans and their organisations, particularly in the economic sector, where family-owned and -operated conglomerates predominate (pp.13-14).

Consequently, Confucian doctrine produced an elite, ruling class known as *Yangban*. In Korean society, Yangban comprised a literati group which constituted the dominant social class of the *Chosun* dynasty. They attained a monopoly on prestige, power and wealth (Oh 1999, p.10). Their tradition embodied socio-political formalities of ceremony, rites, ranks and hierarchical structures. As the Yangban occupied civil and military sides of the government, this class tradition provided for the fundamental formation of a new version of ruling elitism in Korean society and bureaucracy. Thus, Confucian principles as the official creed of government consolidated the power base of the Korean ruling elites, securing a highly centralised authoritarian bureaucracy (Kim and Kim 1997, p.65).

2.3.1.2. Confucianism and Economic Development

Confucian tradition has also strongly influenced economic development in Korea. There were many factors affecting the economic success that occurred in Korea from the 1960s. As Francis Fukuyama (1995) noted⁵, some of these factors were situational

⁵ In his book, *Trust: the social virtues and the creation of prosperity*, Francis Fukuyama explores the ways in which countries that share apparently similar capitalist economic institutions are in fact quite

factors unique to the time but some of the factors were cultural. The legacy of Confucianism in Korea helped to further the goals of industrialisation.

Confucian traditions placed an emphasis on the values of the group over the individual. This helped industrialism by creating a 'pliant populace' who were willing to accept long hours and low wages and not question government policies. The traditions of Confucianism taught workers not to question authority. These traditions carried over into the post war period (1953-1961) and allowed authoritarian regimes (1962-1987) in Korea to go unquestioned by the public. This lack of dissent facilitated Korea to have stable governments, which were crucial to investment and industrialisation. This stability was a direct result of Confucian values being emphasised upon the population. Confucian placement of the group over the individual and its strong belief in filial piety also caused families to accept responsibility for their dependent members. This safety net that was provided by families allowed the government to limit its spending on social welfare programmes and thus channel more funds into infrastructure and industry. Confucianism also placed an emphasis on self-cultivation which has helped Korea to have a skilled and ambitious work force. A large role was played by the traditions of Confucianism which created a pliant and stable populace, skilled and eager workers, and a 'meritocratic' bureaucracy that were skilled at formulating and carrying out economic policy.

different from one another - different in their approaches, work, entrepreneurship, industrial organisation and, ultimately, economic performance. In trying to understand the origins of competitiveness, the chief puzzle concerns why capitalist East Asia grew as fast as it did over the past two generations. Most of the current literature on this subject discusses the problem in terms of either free market or state interventionist policies, but few take seriously the possibility that culture somehow lies at the root of Asian success.

During industrialisation the family in Confucian Korea worked as a powerful social agent protecting its family members. The extended family network functioned as a strong social network; furthermore, the state promoted the family ethos, especially the notion of filial piety, as a means of social control and as the basic strategy for handling social problems. It is said that family problems are regarded as the families' own problems rather than social problems in Confucian Korea.

While several themes have dominated attempts to account for the economic success of Korean society - notably - their distinctive 'developmental states' and their heavy emphasis on education- the most wide-ranging and popularly current explanation is based on culture. Most cultural explanations have in turn been based on some notion of Confucianism, which is held to be a key part of the shared heritage of East Asia as a whole. In an earlier era (the 1950s and the 1960s), Western observers largely perceived Confucianism as a heavy constraint on the economic programme because of its stress on the importance of preserving tradition, its reinforcement of a social structure which despised and restricted commercial and industrial pursuits, and was hostile to technological innovation and entrepreneurship. Since the 1970s, however, Confucianism - in a protean variety of versions - has been rediscovered as a positive historical force. It is now commonly cited as having provided the fundamental cultural underpinnings for East Asian economic success, particularly through its perceived emphasis on education, strong family relations, benevolent paternalism, social harmony and discipline, respect for tradition and a strong work ethic (White and Goodman, 1998).

2.3.2. The Implication of Cultural Factors for Social Policy

The theoretical orientation of Western literature, when applied to the Korean context, downplays certain explanations of Korean social policy, and modifies or extends others. First of all, cultural explanations may be utilised to analyse the policy responses to perceived social problems and the way in which other social problems are individualised within families even though cultural explanations tend to ignore the independent effects of social and political conditions other than cultural values and norms (Woo 2003, p.10). Cultural theorists attribute the unique pattern of the East Asian welfare state to the region's cultural values (Jones, 1990; Park, 1990). From a cultural perspective, Confucianism plays a key role in shaping political actions of East Asian political elites. Because Confucianism has influenced these elites to believe that mutual support among family members and relatives is their primary duty, they may not have developed a strong sense of public responsibility for the well-being of the general population.

Most studies tend to focus on the issue of whether or not there is an East Asian welfare model distinct from its Western counterpart although there have been few studies on the subject produced by Western scholars. However, there are different viewpoints on the characteristics of the East Asian welfare system. Some academics argue that East Asian countries have their own distinctive welfare system, 'the East Asian Welfare Model' (Jones, 1990, 1993; Goodman and Peng, 1995). Jones (1990, 1993) argues that East Asian countries have a Confucian tradition of filial piety and loyalty which has been the overpowering force behind welfare policy in order to contrive 'Oikonomic welfare state'. Goodman and Peng (1995) also argue that these countries have incorporated

many aspects of the Western welfare system, but in practice there is a fundamental deviation from the western experience. On the other hand, others argue that there is little to indicate a distinct 'East Asian Welfare Model' that cannot be grasped with the standard conceptual tools of welfare state theory (Esping-Andersen, 1999; Goodman and White, 1999).

2.4. Summary

This chapter has explored the background of social policy in Korea. This chapter has also examined the interplay of political and economic factors before demonstrating what shaped the development of social policy and what the driving force in shaping social policy in Korea is. As noted over the last four decades Korea has undergone remarkable socio-economic changes due to modernisation, industrialisation and globalisation. Political and Socio-economic factors in social policy making are important in understanding how Korea's mental health policies have been developed and changed. However, the importance of cultural factors should not be underestimated. To make sense of the development and impact of mental health policies in Korea an understanding is needed of the processes by which social policies are made and the cultural contexts in which policy decisions are taken.

It could be argued that mental health policy is one of the most complex in the policy-making arena among the many social policy programmes due to the mixture of variables from social, political and economic factors. That is to say that the mental health policy of any nation contains the distinctive characteristics of its national components.

Thus, each nation shows the distinctiveness of its social policy development although many developing countries have adopted the welfare developmental pattern of the developed countries. Hence, it is necessary to examine the history of the socio-political and socio-economic development of that nation when we observe the evolutionary process of a nation's social policy programme. In the same sense, this study intends to explore the ways in which Korean mental health policy has developed over time.

By adopting Western systems as models in the social, political and economic arenas in the country throughout the modernisation process, Korea has become very Western in its thinking with regard to national values. With respect to this assumption, the question can be raised as to whether the development of the Korean mental health policy can be adequately explained within the context of a purely Western theoretical framework. In the next chapter, some Western theories will be introduced before examining their applicability to Korean mental health policy. Western theories can explain the development of Korean mental health policy.

Chapter 3. Theoretical Perspectives for Mental Health Policy Developments

There has been a wide range of theoretical approaches amongst Western scholars, which have tried to explore accounts for the development of mental health policy (Busfield, 1986, 1996, 1999; Goodwin, 1997; Jones, 1960, 1988; Ramon, 1996; Rogers and Pilgrim, 1996, 2001; Scull, 1977). These diverse perspectives have brought about a great deal of debate over the causes and effects of changing mental health care provision.

As noted earlier, wider discussions about how and why welfare systems have developed and changed is likely to be crucial to understanding mental health policy making. In so doing, before examining the nature of social policies for people with mental health problems, it is necessary to explore theories which provide a theoretical explanation based upon the following particular factors – social and economic changes and the rise of the asylum, and reasons for the policy shift from institutional to community care. From this discussion, some theoretical explanations will be derived for Korea by elaborating how mental health policies have been formulated in the Korean context compared to Western mental health policy development. Although there are numerous studies of mental health policy developments, this study concentrates on three dominant approaches: the logic of industrialism, a Marxist approach and a cultural perspective.

Tracing the creation of large institutions can help us understand their demise. (This is

the assumption behind the work of critical social historians such as Michel Foucault and Andrew Scull). There are two competing accounts giving different interpretations of events and the policy behind the establishment of the asylum system (Pilgrim and Rogers, 1999).

This chapter is divided into four sections including the summary, the first section reviews the literature and arguments that explore the factors affecting mental health policy making in Western European and North American countries (especially the U.K. and the U.S.). Section two tries to examine theoretical perspectives for mental health policy developments. Section three explores the relevant theoretical framework for Korean mental health policy making.

3.1. Mental Health Policy Developments in Western Countries

During the twentieth century there were significant developments in mental health policies and services in West European and North American countries (Goodwin, 1997; Busfield, 1999). These have been analysed in several different ways. In this study, however, mental health policy developments in Western countries will be discussed through two different phases. These are 'the rise of the asylum' and the introduction of the 'care in the community' policy.

3.1.1. The Rise of the Asylum

Over a number of centuries West European and North American countries have developed their mental health services. They opened their asylums for the mentally ill. The asylum was viewed as the 'creation of secure provision for lunatics.' (Goodwin 1997, p.6). In Western Europe, the Bethlem hospital was opened in 1403 in London, England, and the Casa de Orates opened in 1408 in Valencia, Spain (World Health Organization 1955).

From the mid-seventeenth century, a 'great confinement' took place across Europe (Foucault, 1961). Michel Foucault's (1960) pioneering work 'Histoire de la folie a l'age classique' (Madness and Civilisation, 1967) laid the foundations for a critical review of psychiatric history. Often referred to as a 'pre-history' of psychiatry, Foucault's thesis affords a central position to what he calls 'the Great Confinement' in which the mentally ill were rounded up and put into the chief centres of confinement such as asylums, hospital, prisons or jails throughout European countries during the Classical Age (1660-c1800) (Foucault 1965, pp.44-5). In France, the 'great confinement' in the seventeenth century began with the incarceration of the poor, the sick and the mentally disabled in general hospitals, the first of which opened in Paris in 1657 (Foucault, 1973).

The logic of enlightenment values with its emphasis on rationality meant that those that represented 'unreason' were stigmatised and separated from mainstream society. Deviancy of all types embodied in a variety of groups - the criminal, the poor, the lazy,

and the destitute – and which threatened bourgeois values, resulted in their segregation. In addition, Foucault argued, tolerance for the deviant within the community was diminishing throughout the nineteenth century.

In Canada, an asylum was established by the 'religious order' of New France (Quebec) in 1639 'for the care of indigent patients, the crippled and idiots', the 1833 Act was passed to allow relief for 'destitute lunatics' in Ontario and, in 1841, its first asylum was opened (Dear et al., 1979). In the United States an asylum for lunatics was opened in Virginia in 1773 (World Health Organization, 1955). Western European and North American countries established a policy of building asylums for the incarceration of lunatics during the early to mid-nineteenth century. As a result of this, the pace of development increased. In addition, there were parliamentary inquiries and plans for asylum service development in the 1820s in France, England and Denmark. Some European countries, France, the Netherlands, England and Belgium introduced legislation to allow for the building of asylums by the middle of the nineteenth century. (Mangen, 1985; Goodwin 1997).

The 1890 Lunacy Act placed the emphasis on protecting the rights of the public outside the asylum. As a result of this, legal procedures were tightened so that 'the power of the legal profession superseded the power of the medical profession and social policies of the time' (Manning and Shaw 1999, p.6). As Jones points out, this Act had implications which hampered the progress of the mental health movement for around four decades:

The movement for further reform of the law became an (unequal) affair of pressure groups. The legal professional had been fully established for centuries. Medicine was involved in throwing off the shackles of a long association with barbering and

charlatanism, and did not achieve full status until the passing of the Medical Registration Act of 1858....social work and social therapy were to remain occupations for the compassionate amateur until well into the twentieth century. It is therefore not surprising that the legal approach took precedence, to be followed after 1890 by the medical approach. It is only now, where the social sciences have developed a comparable professional status that the social approach is coming into its own again (Jones, 1960, p.23).

As Goodwin points out, however, ‘incarceration of lunatics proved to be an effective nineteenth-century solution to the problem of madness’:

The numbers afflicted were relatively small, and their condition was generally recognised to be severe. With an emphasis upon protecting society from the lunatic, the regulation of admission and discharge was left largely in judicial hands, and for the most part involved compulsion. Reflecting these concerns, the vast majority of the newly created asylums resembled prisons. Their main purpose was to remove the insane from society, and hold them. Inmates were often chained, and conditions were harsh (Goodwin 1997, pp.6-7).

In the late eighteenth century, there were efforts to reform the conditions in which lunatics were held. Goodwin (1997) portrays the situation as follows:

In 1792 at the Bicetre hospital in Paris, Philippe Pinel has chains, which had been worn by some for 30 years, removed from 50 of the inmates and a regime based on moral treatment was introduced. A number of further reforms, such as the creation of a farm, were subsequently introduced by Ferrus at Bicetre, while others, such as Esquirol, sought to introduce a more humanitarian approach to lunatics more widely in France. In England similar ideas were introduced in a Quaker-led initiative by William Tuke and Lindley Murray, who founded the York Retreat in 1796. The use of chains was prohibited, and therapy based on work and exercise and the encouragement of moral behaviour was introduced. These ideas were also of influence in America, with Friends’ Asylum being opened in 1817 in Pennsylvania. Subsequently, Dorothea Dix attempted to take forward the cause of reform in America by campaigning extensively for an improvement in asylum conditions (Goodwin 1997, p.7).

As Grob (1991) points out, however, these efforts to improve the quality of care and treatment within the asylums had a limited effect. He also argues that conditions in asylums tended to worsen and the character of asylums became more custodial during the second half of the nineteenth century due to fiscal constraints and overcrowding (Grob, 1991). Nevertheless, the asylum system grew rapidly over the next few decades and the almost inevitable consequence of being found insane was incarceration by the end of the nineteenth century (Goodwin, 1997).

There have been two major objectives of policy reformers over the last century: initially to reform the asylums, and subsequently to replace them. The first was to reform the custodial asylums into 'proper' hospitals. This was initiated in Britain by the Mental Treatment Act of 1930 which moved the focus away from detention and towards prevention and treatment (Busfield, 1986). It also stimulated the introduction of insulin coma therapy, electronic-convulsive therapy and brain surgery (Manning and Shaw, 1999). Goodwin also points out this:

In the first half of the twentieth century there was some innovation taking place within the old mental hospitals. In the 1930s and 1940s many psychiatrists began to experiment with open-door policies, whereby patients gained some freedom of movement outside of the hospital ward. Efforts were made to increase the therapeutic value of the mental hospital, this including the development of industrial therapy as well as the introduction of a range of new physical treatments including electro-convulsive therapy, insulin coma therapy and psycho-surgery. Concurrent with these developments, admission rates tended to increase, while average lengths of stay tended to decrease. Overall, through the first half of the twentieth century asylums underwent a transition in function, from being primarily custodial institutions towards becoming treatment institutions (Goodwin 1997, pp.7-8).

Before the drug revolution and the decarceration movement of the 1960s, mental hospitals were as much concerned with containing aberrant behaviour as with treating the sufferer. *Asylums*, Erving Goffman's important book about inmate life in a psychiatric hospital, detailed this control process. His book presented an empathic view of the role of the patient and his passage through the treatment system. He focused on a participant observer's viewpoint of the daily interaction between patients, patient and staff and patient and relatives. In addition, he dealt with the process of social exclusion, social control and alienation experienced by inmates of highly bureaucratised psychiatric institutions (Baron, 1987).

As a result of the introduction of the major tranquillisers, the more acute symptoms of mental illness were effectively controlled and long-term incarceration in a mental hospital became unnecessary for most people. Indeed, in the 1960s, there were extensive alternative treatments, for example, day-centres and other non-residential organisations providing care for mental illness. Much of this alternative treatment adopted 'anti-institutional views'. Consequently, more and more people involved in psychiatry, either as carers or on the receiving end of treatment, were beginning to reject the notion of control that is inherent in much of modern psychiatry (Baron, 1987).

3.1.2. Explanations for the Rise of Asylum

3.1.2.1. The Social and Economic Changes and the Rise of the Asylum

The social and economic changes associated with industrialisation and urbanisation are structural factors contributing to the rise of the asylum in nineteenth century Britain (Carrier and Kendall, 1997). There have been some arguments that industrialisation is one of the crucial contributing factors affecting the rise of asylum. For instance, Rogers and Pilgrim (1996) noted that most accounts view aspects of industrialisation as a causal factor in the rise of the asylum. The main features of industrialisation have been summarised as follows:

- (a) A rapid growth in population and geographical mobility;
- (b) Population and production mobility from rural to urban areas;
- (c) A shift away from agricultural to factory-based production;
- (d) A transformation of the social and political ordering of dominant ideals.

(Rogers and Pilgrim 1996, p.46)

According to Mechanic, segregative forms of social control arose as a response to the inability of family-and community-based systems of support to contain illness in the community. Mechanic (1969) writes:

Industrial and technological change...coupled with increasing urbanisation brought decreasing tolerance for bizarre and disruptive behaviour and less ability to contain deviant behaviour within the existing social structure (p.54).

Mechanic emphasises the decreasing tolerance of society for deviant behaviour as inevitably arising from the replacement of old paternal relationships with chaos caused by mass geographical mobility and urban anonymity.

3.1.2.2. Conventional Accounts (Humanitarianism)

This conventional account is sometimes referred to as a 'Whig', or from a feminist perspective a 'great man', version of history. This type of history is usually written by and for the confident and successful and it emphasises the valiant deeds, altruism, and humanitarianism of key agencies and individuals. From such a perspective the asylum is viewed as part and parcel of medical progress and an increasingly humane way of dealing with 'mentally ill' people (Pilgrim and Rogers, 1999).

For instance, Jones (1960) stresses the humanitarianism behind the reform movement leading to the Lunatics Act 1845. This Act compelled county authorities to establish asylums and enforced their regulation via a centralised Lunacy Commission and a system of medical records. Much of Jones's account centres around the official reports of Metropolitan Commissioners between 1828 and 1845 and the role of government-appointed bodies (such as Parliamentary Select Committees), which drew public attention to the poor state of workhouses and private madhouses. The establishment of early institutions modelled on the moral treatment regime of the York Retreat is described as arising from 'the consciousness felt by a small group of citizens of an overwhelming social evil in their midst' (Jones 1960, p.40). In fact, moral treatment failed to transfer from the early charity hospitals like the Retreat to the State-run

asylums, although its image dominated the rhetoric of asylum reformers (Donnelly 1983). Jones (1960) sees the implementation of the 1845 Act in a humanitarian light: 'Ashley and his colleagues had roused the conscience of mid-Victorian society, and had set a new standard of public morality by which the care of the helpless and degraded classes of the community was to be seen as a social responsibility.' (Pilgrim and Rogers 1999, p.145)

3.1.3. The Emergence of Care in the Community

As mentioned before there have been two major objectives of policy reformers during the latter part of the nineteenth century: initially to reform the asylums, and subsequently to replace them. As the conditions within asylums worsened further, the efforts to develop alternative systems of care and treatment emerged.

Perhaps most famous of these schemes was that begun at Gheel in Belgium, where its shrines were reputed to offer a cure for lunacy. If no cure resulted within nine days, the lunatic would then be boarded out with a local family in order that they might continue to attend church. The practice of boarding-out lunatics with families subsequently developed in many European countries, including Germany, France, the Netherlands, Belgium and the Scandinavian countries (World Health Organization, 1955, p.7).

The new emphasis upon mental health care outside of the asylum continued to grow in the early twentieth century (Goodwin, 1997).

By the 1920s the mental hygiene movement had established associations in a number of European countries and in the United States. By the 1930s there were small-scale developments in a range of extramural services. This included domiciliary support, the

development of child guidance, marital counselling services and outpatient services. While not common, these types of service began to emerge in various towns and cities across Europe and North America (Goodwin 1997, p.9).

Many European countries had considerable experience in mental health services provision in the aftermath of World War II. In addition, there were also a number of initiatives for people with mental health problems in the community as a means of ensuring their survival (Demay, 1987). Since the early 1950s, there have been moves towards community care in many western countries. This resulted in reductions in hospital places in Britain, the US, and other European countries (Busfield 1999).

There has been the shift from asylum care to community care resulting from a distinct change of policy: from a model of services for those disturbed in mind centred on the asylum, to a model of services located in an centred on the community (Busfield 1999, p.58).

It has been estimated that over half a million long-stay patients have been discharged from mental hospitals in the United States and the United Kingdom since the 1950s (Lamb, 1993). This extensive change in mental health care has been advocated by successive British governments since 1961, and Enoch Powell, then health minister, gave this statement on the closure of 75,000 beds in asylums by 1976:

There they stand, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakably and daunting out of the countryside, the asylums which our forefathers built with such solidity. Do not for a moment underestimate their power of resistance to our assault (Enoch Powell, 1961).

In case of the United States, a crucial improvement was given to de-institutionalisation when President John F. Kennedy (1963) sent a message to Congress that announced

America's first, and only, federally operated community mental health initiative. In that year Kennedy spoke of pursuing a 'bold new approach' in mental health service delivery, three words that eventually became the by-words of the de-institutionalisation movement (Lamb, 1993).

Over the twentieth century, mental health services outside of the hospital, such as outpatient services and day care services, were developed. There was also a range of new community centred care services for discharged patients including community mental health centres, and the establishment of multi-disciplinary community-based psychiatric teams involving general practitioners, community psychiatric nurses, psychiatrists, psychologists and some other staff groups (Goodwin, 1997). With a variety of insurance schemes, Western European and North American countries have a number of common patterns and trends in mental health services. In few countries, including England, Denmark, Italy and Canada, services funded by general taxation have emerged (Goodwin, 1997). There has been a general trend towards more varied and more community centred mental health care for those with mental health problems. Many of the older hospitals have been run down or closed. At the same time, new psychiatric units have been established in general hospitals.

There has been a 'global trend' in that many other industrialised countries have tended to develop community mental health care for those with mental health problems (Goodwin, 1997). Malaysia, for example, has made substantial progress in transferring mental health service users from institutional to community settings in recent years (Salleh, 1993). In Israel, mental health legislation was implemented in 1991 which seeks to increase patient rights and to avoid unnecessary hospitalisation (Levy, 1992). In

1992 the health ministers of all-Australian states and territories, together with the federal government, endorsed a National Mental Health Policy. This laid out plans to promote the development of community-based services, together with their better integration with remaining institutional services (Whiteford, 1993).

There have been significant changes in the way in which people with mental health problems are treated and cared for in Western Europe and North American countries in the aftermath of World War II, even among many other industrialised countries around the world in recent years. In this respect, the question that arises is why this has occurred and what forces, in what combination, have brought about such a rapid, widespread and dramatic policy shift?

In the early 1960s there were some plans to reduce the number of long-term mentally ill patients in hospital in North American and Western European countries (Goodwin, 1997). Many long-stay hospitals were closed through the pursuit of a 'care in the community' policy (Hadley and Clough, 1996). This policy appeared to be successful in providing an opportunity for long-term mentally ill people to live in their own home and community and be supported by health and social care services. People with mental health problems were given individual rights to protect them from poor inhumanitarian services and to provide 'needs-led' services which provided for 'highly differentiated treatment needs' (Tomlinson 1991, p.162).

There were some policies and projects aimed at seeking good practice and to continue a care in the community policy for those with mental health problems in the 1970s and 1980s. These policies and projects were designed to support and help families of the

mentally ill, provision of suitable accommodation and housing and social support. They also emphasised the development of community care (Renshaw et. al, 1995). Hadley and Clough argued that there were five general themes that affect the development of community care; 'the growing resource', 'base of public services', 'rising demands', 'professionalisation', 'changing patterns of treatment' and 'de-institutionalisation' (Hadley and Clough 1996, p.10). Many industrialised countries around the world are now tending towards developing community-based policies for people with mental health problems.

As Dear and Wolch (1987) argue, a combination of factors is responsible for the policy shift: 'The idea of the care in the community approach was a response to new treatment philosophies, major advances in chemotherapy, a concern with patient's rights and fiscal pressure' (Dear and Wolch 1987, p.250).

In addition Hafner and his colleagues argue that there are three main reasons for the shift in policy in European countries: 'the neglect of mental hospitals and the resulting criticism of their condition; the shift within psychiatry towards a more therapeutic orientation; and the increasing emphasis upon civil rights, liberty and quality of life for chronically sick and disabled people' (Hanfner et. al. 1989, p.12).

The demand for community-based mental health care was subsequently intensified by economic problems. Within this range of factors explaining why community-oriented mental health care services have tended to replace institutional care, a pattern emerges in terms of type of explanation developed in different accounts. Some, particularly Jones tend to stress the importance of new drug treatments for people with mental

health problems, and humanitarian concerns such as those contained in the anti-institutional critiques. Others, particularly Scull, tend to stress the importance of structural factors, particularly those deriving from the nature of capitalist societies. This concerns factors such as the cost of service provision, and problems associated with the maintenance of social control (Scull, 1977).

As Goodwin (1997) points out, there have been a number of problems affecting community care policies in Western countries.

- (a) Hospital and community support services: transinstitutionalisation; a two-tier service; the revolving door; the lack of community care facilities; the poor quality of some community care facilities; the inadequate range of community care facilities
- (b) The outcomes of community care: the discharge process; the destination of discharged patients; family care; homelessness.
- (c) Use of treatments: side effects of drug treatment; compulsory treatment in the community; the physical and mental health of service users.

Goodwin has also noted that ‘a lack of resources devoted to the development of adequate alternatives to institutional care, together with a lack of concern for the quality of life of informal carers or of service users, has tended to characterise the development of community care policy’ (Goodwin 1997, p.27). Despite this, in recent years the Korean government has introduced a care in the community policy for people with mental health problems. Korea has made substantial progress in transferring mental health services users from institution to community settings in recent years. This trend of community-oriented mental health care appeared in Korea as a policy shift toward community oriented services provision by the mid-1990s. In 1995 Korea passed a mental health law for the first time in order to protect some individual human rights,

and it allowed for the creation of some community-based programme models. It has generally come to be accepted that people experiencing mental health problems are better provided for in the community than in hospital care. Accordingly there has been a massive shift in emphasis from the provision of inpatient care in mental hospitals, towards the provision of a more varied and community-based set of services.

3.1.4. Explanations for Policy Shift towards Community Care

There have been various origins of the policy of care in the community. Ramon (1992) described three factors influencing the policy of long-stay psychiatric hospital closure. The first is evidence of the effectiveness of alternative community-based interventions and medical treatments. The second is political support deriving both from the perceived financial savings to be made by hospital closure, and from the fact that community-based services are considered to provide a more 'respectful' way of treating fellow citizens. The latter is a sociological critique of the segregating and stigmatising effect of total institutions.

However, Busfield (1986) attempted to summarise explanations for the trend of large hospitals being run-down and closure. She presents three main models:

- (a) The pharmacological revolution – introduction of psychotropic drugs and acceptance of institutional critique;
- (b) Economic determinism – increased costs of segregative control plus the fiscal crisis of the state;

- (c) A shift to acute problems – undermining of belief in the therapeutic value of institutions; development of non-institutional forms of welfare; medical advantages of integration; therapeutic optimism.

Additionally, in his study of *the Comparative Mental Health Policy: from institutional to community care*, Goodwin (1997) presents a comparative analysis of mental health policy in Western Europe and North America. He considers how, and why, differences have developed in the implementation of these policies. As a focus for his study he used a range of types of explanation (see Table 3.1.) about the policy shift towards community-based services for people with mental health problems.

What we find, therefore, is a range of types of explanation, from orthodox, which tend to stress the positive and beneficial aspect of the policy shift, to the radical, which tend to stress the negative and detrimental consequences of the shift to community-based systems of care and treatment (Goodwin 1997, p.28).

Table 3.1. Reasons for the Policy Shift

| Orthodox Accounts | Radical Accounts |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| (a) The development of new drug treatment. | (a) High public welfare expenditure is a cause of economic problems. |
| (b) The development of social psychiatry. | (b) High public expenditure growth is associated with a tendency towards deinstitutionalisation. |
| (c) The emergence of radical analyses, together with the civil rights movement. | (c) High fiscal deficits result in pressure for deinstitutionalisation. |
| (d) The poor conditions within the old mental hospitals. | (d) The retention of institutional care results in increasingly large opportunity costs. |
| (e) Increased community tolerance. | (e) An inverse relationship can be found between levels of unemployment and mental hospital bed space. |
| (f) The wishes of people with mental health problems to live, whenever possible, within community settings. | (f) Community care is cheaper than institutional care. |
| (g) A federal constitutional structure has tended to facilitate a more rapid shift in policy. | (g) Government policy is determined by economic issues. |
| (h) Insurance-based funding systems have tended to hinder the policy shift. | |

Source: Adapted form Goodwin (1997)

Goodwin (1997) explains 'orthodox accounts' of policy shift:

By the term 'orthodox accounts', we are referring to those explanations and descriptions of policy development that offer a conventional understanding of policy change. Such accounts tend to be pluralistic, offering a range of factors to accounts for post-war change in mental health policy (p.29).

In contrast, he explains 'radical accounts' of policy shift:

Rather than focus upon particular ideological currents, administrative arrangements or other intricacies of public policy-making, Marxist and other radical writers tend to focus upon broad analytical themes associated with the more general nature of social and economic arrangements. A central contention is that the post-war mental health policies of Western European and North American countries have largely been shaped by financial pressures (Goodwin 1997, p.51).

Within this range of factors concerning why community-based services have tended to replace institutional care, a pattern emerges in terms of the type of explanation developed in different accounts. Some, especially Katherine Jones, tend to stress the importance of new drug treatments, and humanitarian concerns such as those contained in anti-institutional critiques. Others, especially Andrew Scull, tend to stress the importance of structural factors, particularly those deriving from the nature of capitalist societies. This concerns factors such as the cost of service provision, and problems associated with the maintenance of social control (Goodwin, 1997).

3.1.4.1. 'Orthodox' Accounts for the Policy Shift

The post-war policy shift towards community care has been explained in a number of different ways. A standard account, often favoured by psychiatrists, links it to the therapeutic developments of the post-war 1950s, and, to a lesser extent, to the impact of the sustained and vocal critiques of institutional care that come from both within and outside psychiatry during the same decade. The chemically synthesised drugs of the 1950s permitted, it is contended, a greater number of patients to be treated outside the hospital and facilitated the earlier discharge of those who did have to be admitted. This, together with an increasing recognition of the anti-therapeutic nature of institutional care led, it is argued, to general support for policies of shifting care away from the mental hospital towards the community. Busfield (1986) attempted to characterise the policy change and the explanation that is offered of it in terms of the simple model set out in Figure 3.1.

According to Shaw (2000), in the UK 'moving the locus of treatment away from the asylums by developing broad systems of community care was one of the objectives of the 1930 Mental Health Treatment Act. This Act had given the local authorities permissive responsibilities for the aftercare of those discharged from hospitals, though it was not until the "three revolutions" of the 1950s that a significant move towards community care occurred' (Shaw 2000, p.106).

- (a) The first 'revolution' was the introduction of new drugs. Chlorpromazine (largactil), although sedative in effect, enables patients to continue daily activities while being relieved of the more disturbing symptoms of their illness;
- (b) The second 'revolution' was an administrative one which involved the modernisation of hospitals to utilise a wide range of services, such as in-patients,

outpatient units, day care, and hostels, which facilitated the development of community care;

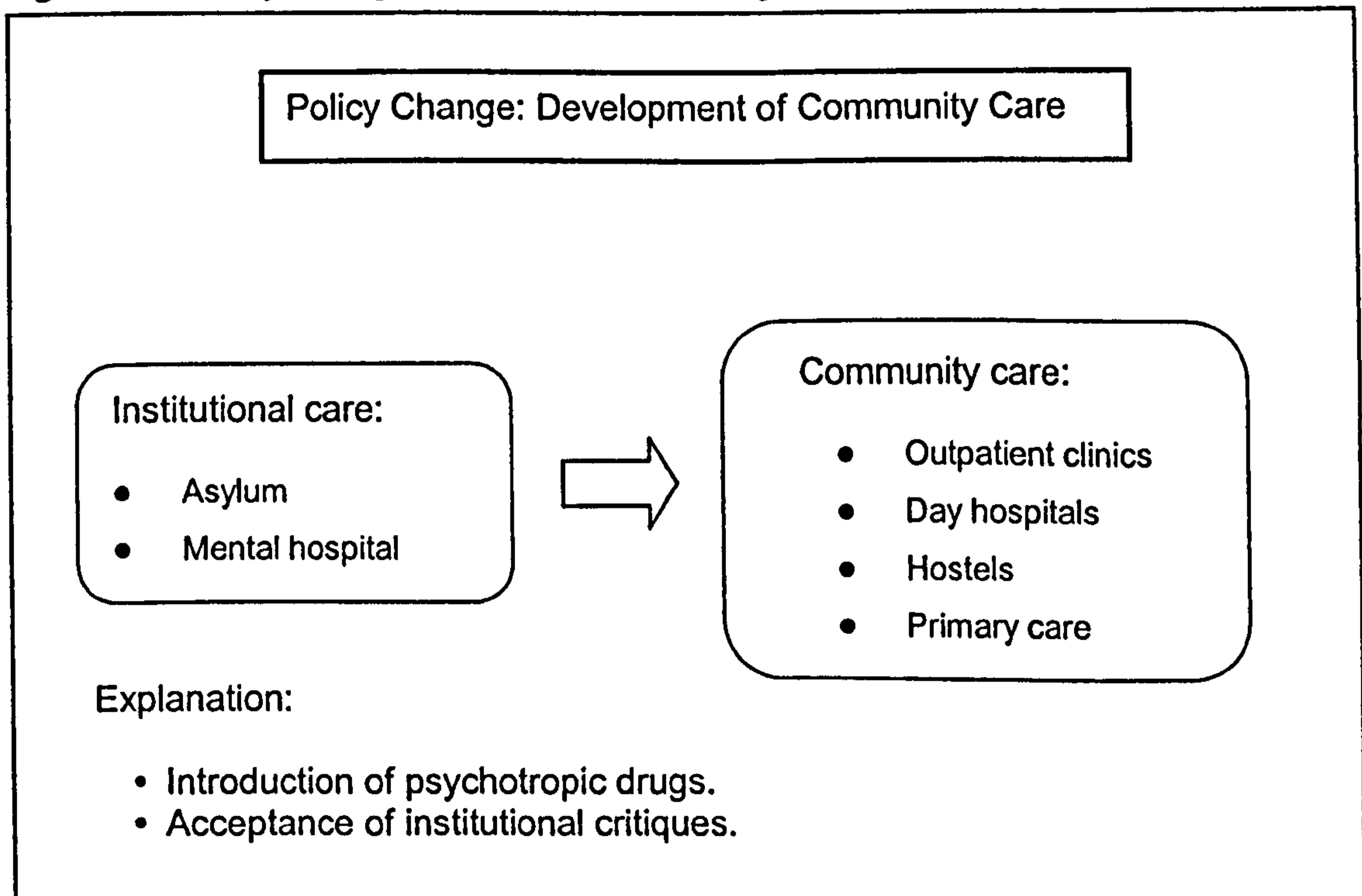
- (c) The third 'revolution' involved legal reforms brought about by the 1959 Mental Health Act. This abolished compulsory admission as the regular means of admission and aimed to reorient the mental health service away from institutional care towards community care

(Shaw 2000, p.106).

In addition Goodwin (1997) attempted to explain reasons for the policy shift. He called it 'orthodox accounts':

By the term 'orthodox accounts', we are referring to those explanations and descriptions of policy development that offer a conventional understanding of policy change. Such accounts tend to be pluralistic, offering a range of factors to accounts for post-war change in mental health policy (p.29).

Figure 3.1. Policy Change and its 'Orthodox' Explanation



Source: Busfield, 1986.

He also attempted to add some reasons for the policy shift into the existing explanation.

These are:

- (a) The development of new drug treatment;
- (b) The development of social psychiatry;
- (c) The emergence of radical analyses, together with the civil rights movement;
- (d) The poor conditions within the old mental hospitals;
- (e) Increased community tolerance;
- (f) The wishes of people with mental health problems to live, whenever possible, within community settings;
- (g) A federal constitutional structure that tended to facilitate a more rapid shift in policy;
- (h) Insurance-based funding systems that tended to hinder the policy shift.

(Goodwin, 1997)

There are series of problems with many of the propositions in the orthodox analysis. Goodwin (1997) argued that the only proposition that could be accepted is 'the tendency of insurance-based funding systems to hinder policy change'. In addition, other factors, such as the introduction of new drugs, and the role of social psychiatry, were all highly problematic.

Furthermore, critical historians reject this more conventional account of events. The incarceration of mad people in asylums is seen as inextricably linked to the wider-scale containment of social deviancy: the poor in workhouses and criminals in prisons. The accounts of alternative histories vary (Pilgrim and Rogers, 1999).

3.1.4.2. Radical Accounts for the Policy Shift

While some commentators accepted the orthodox account for the policy change, there has been the radical explanation of the policy shift from institutional care to community care for those with mental health problems. Goodwin (1997) explains 'radical accounts' of policy shift:

Rather than focus upon particular ideological currents, administrative arrangements or other intricacies of public policy-making, Marxist and other radical writers tend to focus upon broad analytical themes associated with the more general nature of social and economic arrangements. A central contention is that the post-war mental health policies of Western European and North American countries have largely been shaped by financial pressures (p.51).

There are a number of problems with this explanation of the shift to community care, grounded as it is in the liberal-scientific view of medical work, as Scull in his book *Decarceration*, and others, have indicated. First, it is defective on grounds of timing.

The decline in the size of the resident population of psychiatric beds was apparent in national statistics for the UK and in the US in the mid-1950s and in the statistics for particular hospitals from at least the beginning of the 1950s, yet the chemically synthesised drugs were only just beginning to be introduced in the mid 1950s (Scull 1977, p.82).

Scull presents a second objection to the thesis: that there is little evidence that psychotropic drugs have been very effective in curing mental disorders. In his words there is 'a growing volume of evidence which suggest that claims about the therapeutic

effectiveness of so-called “anti-psychotic” medication have been greatly exaggerated’ (Scull 1977, p.82)

Scull has presented us with an alternative description of the policy transition and an alternative explanation that questions the benevolent assumptions of the liberal explanation. For Scull, the key policy change is a negative one: the rejection of the asylum; he uses the term decarceration as a ‘shorthand for a state-sponsored policy of closing down asylums, prisons and reformatories’, a policy more commonly described as deinstitutionalisation (Scull 1977, p.1). According to Scull this represents a movement away from what he calls ‘an institutionally based system of segregative control’ (Scull 1997, p.64). He measures the adoption of this policy by the decline in the number of resident patients in state mental hospitals in the US and the UK since the mid-1950s, a decline more substantial in the US than in the UK and one that he recognises is far from complete in either country.

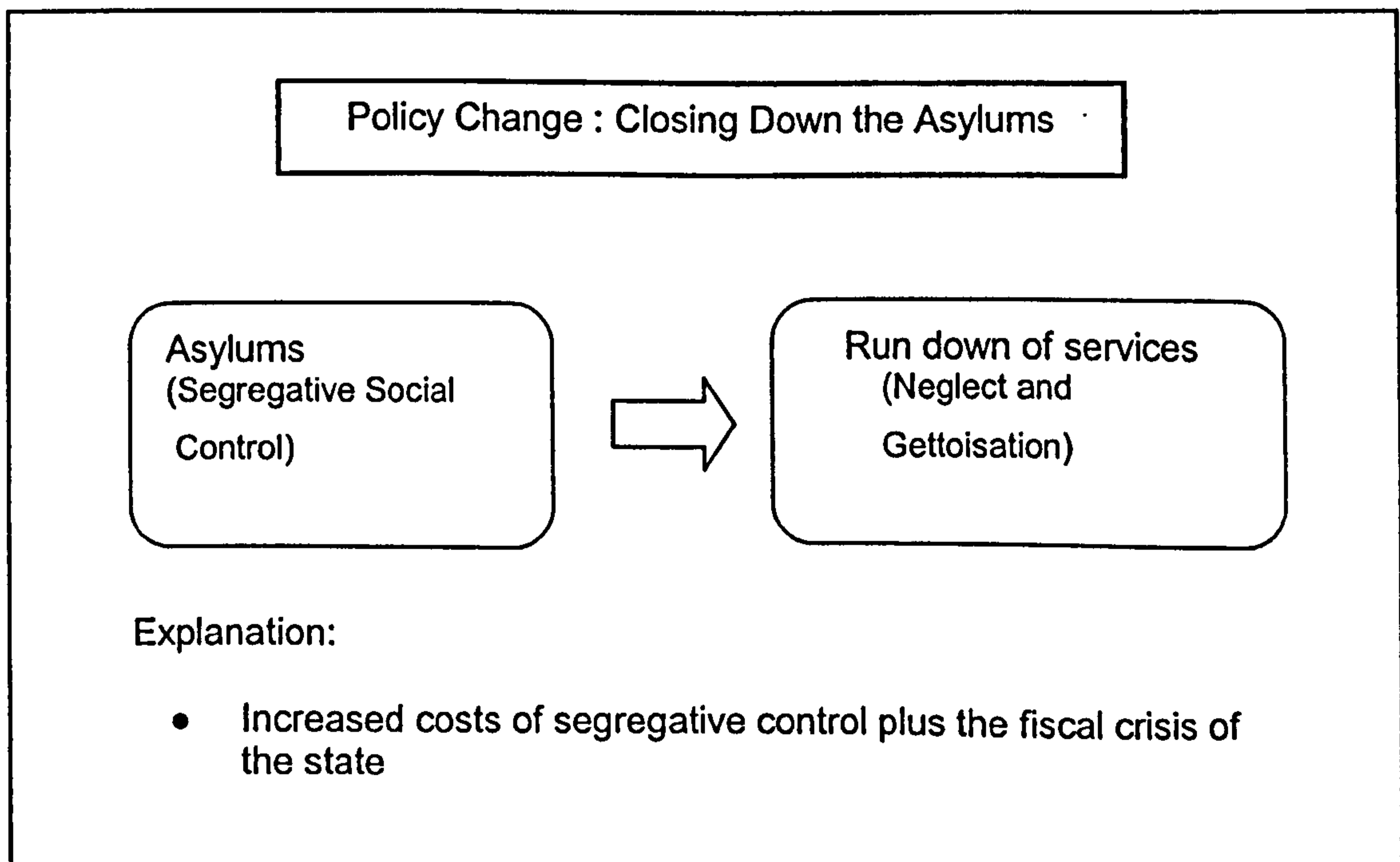
Scull’s description of the transition is not, therefore, of a move from mental hospital care to community care but from segregation in the asylum to neglect and misery within the community. This description of the nature of the transition generates its own explanation: that the main reasons for the adoption of the new policy were economic. Decarceration was introduced because ‘segregative modes of social control became, in relative terms, far more costly and difficult to justify’ (p.135). For him the anti-institutional ideology of the 1950s may have facilitated decarceration but was not in itself sufficient to account for its adoption. As evidence, he points to the critique of institutional care in the nineteenth century, which he asserts had little real impact.

Bustfield (1986) presents Scull's interpretation of decarceration and its explanation in Figure 2.2.

Furthermore Goodwin (1997) attempted to add some reasons for the policy shift into the existing radical explanation in terms of 'radical accounts'. These are:

- (a) High public expenditure growth is associated with a tendency towards de-institutionalisation;
- (b) High fiscal deficits result in pressure for de-institutionalisation;
- (c) The retention of institutional care results in increasingly large opportunity costs;
- (d) An inverse relationship can be found between levels of unemployment and mental hospital bed space;
- (e) Community care is cheaper than institutional care;
- (f) Government policy is determined by economic issues.

Figure 2.2. Policy Change and its Radical Explanation



Source: Busfield, 1986.

As Goodwin (1997) mentioned, the radical analysis of the development of mental health policy includes 'a number of assumptions about the nature of the relationship between capitalist economies and welfare provision' (p.65). He argued that the concerns of governments with the economic cost of welfare provision and the possibility of achieving cost savings through the shift towards community-based mental health care are evident. These radical accounts have been mainly advocated by Scull (1977) who argues that after the Second World War governments increasingly struggled to contain the fiscal pressures of the welfare state. Given that institutional care or segregate control was expensive, the large hospitals could be eliminated to save money.

3.2. Economistic Explanations for Mental Health Policy Developments

It could be argued that social policies are always changing according to domestic socio-economic structures, internal influences, as well as changes in international markets, external influences (Powell and Hewitt, 1997). In this respect, Korean mental health policy has been largely influenced by structural factors due to the process of industrialisation (internal influences) and globalisation (external influences).

3.2.1. Logic of Industrialism

In Western Europe and North America the early development of mental health services is generally recognised to be a product of the emerging industrial societies. In the

eighteenth and nineteenth centuries, the shift of populations from rural to urban areas created a problem of maintaining social order and of meeting the needs of a newly formed urban mass (Goodwin, 1997). Within the emerging market economies, lunatics, more obviously than the physically sick, elderly and children, were less able to conform to labour market discipline and more able to create disturbance and disorder (Scull, 1979).

Not everybody could support himself or herself in the market, nor would they necessarily find support from the church, charity or family. Or, where such support was made available by a family member, their own ability to participate in the labour market was constrained. People with mental health problems, therefore, were one of the first potential welfare clients to be recognised by governments as a distinct group who had the right to social benefits without the need for labour market participation (Goodwin, 1997).

The creation of asylums in Europe and North America has been argued to represent one part of the response made to these issues: 'Throughout Europe, confinement constituted one of the answers the seventeenth century gave to an economic crisis that affected the entire Western world' (Foucault 1973, p.49). In his analysis of the origins and development of the asylums in the United States, Rothman (1971) develops a similar analysis:

In this period, psychiatrists were more American than they were scientific, and the nature of their response to insanity cannot be comprehended unless one recognises that they defined mental illness as a social problem, not just a medical one.... Prisons, poorhouses and orphan asylums grew up at the same time, and this coincidence suggest that the society was reacting to more than psychiatric doctrines (p.xv)

Furthermore, Scull, a Marxist, suggests that mass confinement (of which the asylum system constituted an integral part) was a product of urbanisation, industrialisation, and professional forces during the first half of the nineteenth century. The development of capitalism, with its demand for wage labour, meant that the existing means of poor relief was ill-equipped to deal with social deviance produced by the new market economy. Thus, the old outdoor system of relief in operation since the Elizabethan Poor Law was replaced by mass incarceration in institutions (Pilgrim and Rogers, 1999).

From the beginning of the nineteenth century a gradual process of segregation took place. Poor, able-bodied people (that is those fit to work) were sent to workhouses, which were orientated towards instilling 'proper work habits'. These people were separated from those that could not work, which included those deemed insane and in need of incarceration in asylums. At the same time, ideas about madness were changing. It became recognised as a loss of self-control and not, as previously, a loss of humanity. These changing values were influenced by the exposure of the brutal treatment of those in madhouses. This encouraged the abandonment of mechanical restraints and it endorsed regimes such as the York Retreat (Pilgrim and Rogers, 1999).

These new social values permitted a greater willingness to accept a medical view of madness, the ascendance of which Scull attributes to the entrepreneurial leanings of medical practitioners, who were at the same time making efforts to professionalize and expand. Lucrative pickings were to be had by the profession trying to capture the madhouses previously run by laymen. Rather than having to attract patients to them, the asylum provided them with a ready-made and captive clientele (Pilgrim and Rogers 1999, p.145).

The logic of the industrialism approach shares many similar points to functionalist perspectives in how it accounts for the development of social policy. This approach explains that social policy programmes are necessarily born to deal with the impact of social transformation into an urban-industrial society. Because urban-industrialisation and technical evolution cause massive changes in the structure of the family, community, labour and demography, government ultimately responds to these rapid social changes by bringing a means of social policy.

This theoretical perspective offers a possible approach for the interpretation of the Korean case. Since the Korean War, the country has succeeded in making rapid economic development during the last four decades. This huge economic achievement has resulted in tremendous social transformations in the areas of the family, demography, social structures and so on. While enjoying economic growth, the country has also adopted welfare programmes. During the socio-economic evolution, the question could be raised as to whether economic development contributed to the development of welfare programmes in Korea. As the mental health policy was initiated and implemented alongside economic growth in Korea, economic growth may be a critical variable to explain Korean welfare development in general and mental health development in particular.

With regard to the logic of industrialisation, thus, two controversial issues became apparent with respect to the Korean experience: first, even though the industrialisation approach provides an explanation for mental health policy development, the efforts of political actors in the policy-making arena should be considered; second, although industrialisation has brought progress, it has also contributed to the collapse of

traditional social welfare mechanisms in Korean society. For example, neighbours have traditionally depended on each other for assistance during times of crisis. Unfortunately, industrialisation has led to the breakdown of these informal networks and created a need for the development of formalised welfare programmes.

3.2.2. Marxist Perspectives

Scull (1977) provides an alternative explanation for ‘decarceration’, the term he uses to describe the ‘... State sponsored policy of closing down asylums’, which he relates to changes in social control mechanisms. Scull contends that, with the emergence of the welfare state, segregative control mechanisms became too costly and difficult to justify. The cost inflation of mental hospitals prior to, and after, the Second World War was brought about by the elimination of unpaid patient labour and the increased cost of employees, as a result of the unionisation of labour. The latter had the effect of contributing to the doubling of unit costs (because of the cost of a shorter working day and holiday entitlement) (Pilgrim and Rogers, 1999).

The maintenance of ex-patients on welfare payments and the ‘neglecting’ of community care has become a more viable State policy. The reality of community habitation for ex-inmates, according to Scull, has been an unmitigated disaster for the majority. The inhumanity of the asylum has simply been replaced by the negligence of the community: ‘the alternative to the institution has been to be herded into newly emerging “deviant ghettos”, sewers of human misery, which are conventionally defined as a social pathology within which (largely hidden from outside inspection or even notice)

society's refuse may be repressively tolerated' (Scull 1977, quoted in Pilgrim and Rogers 1999, p.153).

Some academics argue that a capitalist state has to achieve the goals of legitimation and accumulation. In the 1970s and 1980s neo-Marxists such as O'Connor (1973), Gough (1979) and Offe (1984), believed that the capitalist state would face an inbuilt and inescapable crisis. According to O'Connor (1973), a capitalist state will have to fulfil two basic functions – accumulation and legitimation – and public expenditure is required to meet these functions. As he predicted, the 'fiscal crisis' has been triggered by a gap between state revenues and expenditure in fulfilling these two contradictory tasks. This is because the state's welfare burden becomes heavier as more of the population become dependent on state help. For O'Connor, there is no alternative means for handling such an inbuilt conflict.

As Busfield (1986) argues, in the case of the United Kingdom the fiscal pressure hypothesis fits poorly with the period of the 1950s and 1960s when the policy of de-institutionalisation was introduced (on paper if not in practice) and fits better for the 1970s and after. The latter has been a period which we have already noted was associated with rigid efforts on the part of both the Labour and then Conservative administrations to contain welfare spending.

During the 1970s a Labour administration had struggled with debt problems amplified by the OPEC oil crisis in 1973 and had to approach the International Monetary Fund for a loan. A condition of this arrangement was that public spending had to be brought under control. And so a Labour government began a period of welfare cuts even before Thatcher came to power in 1979. The crisis of the British welfare state can be viewed as endemic to any capitalist country which attempts to solve its social

problems by the use of public finance. This financial consideration put pressure on expensive institutions like the Victorian asylum system, but the latter had in any case been losing their credibility since the mid-1960s. Thus the run-down of the old asylums gained momentum for both economic and ideological reasons. Indeed, whilst economic factors were influential, it is worth noting that asylum run-down, and the absence of new large institutions being commissioned, had become a global trend, independent of particular nation-state economic conditions. Sometimes a reaction against the large hospital and for new community developments was stronger in some capitalist countries during the 1960s and 1970s (e.g. the US and Italy) than in others (e.g. Spain and Japan) (Roger & Pilgrim 1996, p.77).

Hospital closure was not utilised in the US case as an opportunity to change the system, the attitudes or the skills of providers and purchasers, nor to increase the involvement of the lay community. Ramon (1996, p.30) argues that 'this was the case because the aim of the government, and a number of professionals, was not to reach beyond de-hospitalisation. The latter was a finite objective for a cost-cutting exercise, as demonstrated by cuts in the budgets of community mental health centres a few years later'.

In addition, the costs of mental health problems to a nation are substantial. This fact, together with the relatively difficult fiscal conditions faced by many governments over the last three decades, leads most writers to accept the importance of economic factors in the determination of mental health policy (Goodwin, 1997). Even, Jones, who supports orthodox accounts of policy shift, mentioned the important role of economics.

... the discovery by governments that welfare policies had limits, and that citizens were liable to demand far more in the way of services than they were prepared to pay for through taxes; and a new economic situation after the crisis of 1973, in which monetarism was dominant, public sector expenditure was reduced, unemployment was widespread, and welfare services were cut to the bone. These factors, common to

all countries in the Western world and involving some curious and contradictory reasoning, brought about similar results in quite different national contexts (Jones 1988, p.82).

A leading advocate of this position is Andrew Scull. He maintains that over the post-war period governments in the advanced capitalist countries had become increasingly prone to 'fiscal crisis': a condition when tax revenues tend to decline while demands for social expenditure tend to increase, resulting in a growing fiscal deficit. The process of de-institutionalisation has primarily been the result of a need to reduce costs, and the ideology of community care has provided the legitimating cover under which that programme commenced (Goodwin 1997, p.52).

Scholars of social policy have paid considerable attention to the part that economics plays in the policy-making process. Richardson (1969, p.96) notes that 'economics imposed certain constraints upon political action. Purely economic factors were an incentive to government action because of the need to increase the efficiency of the nation's economy'.

Marxist and other radical writers tend to focus upon broad analytical themes associated with the more general nature of social and economic arrangements rather than focus upon particular ideological currents, administrative arrangements or other intricacies of public policy-making (Goodwin 1997, p.51). Moreover, there is an important point about the cost of health problems to a nation. Goodwin (1997) explains this:

The cost of mental health problems to nation is substantial. This fact, together with the relatively difficult fiscal conditions faced by many governments over the last 20 years or so, leads most writers to accept the importance of economic factors is the

There are various propositions to account for the policy shift from institutional to community care for people with mental health problems. One of them is 'government policy is determined by economic issues', which means that governments are largely driven by economic imperatives (Goodwin 1997, p.62). Economic problems have resulted in a reduction in the commitment to welfare provision and a shift towards community-based care because of its assumed relative cheapness (Carrol, 1993). Goodwin (1997) gives us some evidences to justify this:

It is argued that the tendency to shift from institutional to community care since the 1970s has been driven by cost considerations: 'As the crisis of the welfare state has deepened, official preoccupations with community care have progressively narrowed down to the paramount question of cost'. Indeed the desire to save money has been key to the process of de-institutionalisation. In many European countries 'these policies are driven largely by ideas of reducing expenditure-namely that it is cheaper and more cost-effective to care for people in the community (p.62).

Scull's replacement of a technological determinist argument with an economic determinist one also gives rise to empirical and conceptual difficulties. In particular, his account has been deemed defective on the grounds of timing (Pilgrim and Rogers, 1999). Busfield points out that the State's fiscal crisis (which is the main reference point for Scull's thesis) characterises the post-1970s era. During the 1950s, when American deinstitutionalisation policies developed rapidly, the economic growth which accompanied increases in public expenditure meant there was relatively little concern about the latter. Scull's explanation also fails to acknowledge the rise in expenditure and development of mental health services outside the hospital sector. There have, for example, been large increases in psychiatric services in the area of primary care. Rather

than the non-provision of services, Busfield has argued that community care has brought with it a shift in orientation from the chronic long-term patients towards those with acute or less serious problems (Pilgrim and Rogers 1999, p.154).

The Marxist perspective provides a tool for examining the relationship between the development of welfare programmes and the conflicts among different socio-economic classes. This is inevitably produced by the profit-driven mechanism of capitalist countries. In Korea, export-driven economic development has allowed for the excessive accumulation of capital by a relatively small number of large corporations, the so-called *Chaebol* (Conglomerate). This tactic facilitated rapid economic development and resulted in the strong control of labour to maintain a stable economic growth in the country. This kind of economic system caused unfair competition and an over-use of power by a limited number of capitalists. In Korean society, the redistribution of wealth has been uneven among classes, and the gap between rich and poor has widened.

As Marx predicted, these social outcomes produced by economic development under capitalist formation were sufficient to bring about conflicts between capitalists and labour. In Korea, however, this theoretical perspective does not explain appropriately the initiative of the first social welfare law and its implementation which occurred during the 1960s and 1970s. Since labour was heavily controlled by an authoritarian government, it was almost impossible to take any collective action against the government or employers. Thus, there was no sign of conflict between labour and capitalists in the policy-making process of mental health care. This conflict became evident, however, during the democratic movement in the 1980s. Government officials and entrepreneurs found that the increasing number of labour disputes and the

escalating demands of the labour force became a tremendous challenge. It is interesting to see how the labour movement impacted on Korean social welfare development with respect to government intervention in these issues. In respect to this matter, we can raise two questions: 'How has the Korean government reacted to the class conflict?' and 'Was the welfare provision a measure of the government to undermine the conflict?'

Secondly, according to Marxists' views, labour is considered as a means of production in the capitalist mode. Thus, welfare is a provision from the bourgeois to preserve the health of labour that guarantees an increase in productivity. In Korea, however, demands for welfare provisions from the entrepreneur side were not found. Therefore, it cannot be said that the welfare development of Korea was attributed to the efforts of the bourgeois to preserve a high quality-labour capacity.

Finally, this Marxist theory is further limited by its narrow definition of capitalism. It implies that every country will have an identical experience under the capitalist approach. We know that this is not the case when we compare the result of capitalism in different national settings. For example, two capitalist styles, Scandinavia and the U.S., show us a prominent differential in interpreting welfare development (especially regarding health care policy). Each country has used a distinct method for dealing with social matters based upon its interpretation of the functions of capitalism. In Scandinavia, the social democratic method was used, whereas a liberal-market approach was adopted by the U.S.

3.3. Towards a Relevant Theoretical Framework for Korean Mental Health Policy Making

It is generally acknowledged that historical and socio-cultural conditions are important in determining the particular shape of social welfare systems. It is also said that the development of new policies can be explained in terms of the effects of specific social pressures on a government. In this respect, the emergence of mental health policy reflected the Korean government's intention to cope with economic, social and political pressures through its strategic choices. The development of the Korean mental health policy seems to be the unique and complex result of economic, social and political conflict in the country.

3.3.1. Relative Advantage of Cultural Perspective over Existing Theoretical Perspectives

It is said that the importance of cultural influence on social policy should not be underestimated. Because welfare state policies and culture are mutually interrelated in a very complex way and sometimes also contradictory ways. In this regard, the literature and arguments that explore cultural influences on social policy will give us another appropriate analytical framework to understand how Korean mental health policies have been developed and changed along with a structural approach.

In this regard, the literature and arguments that explore structural influences have limitations to understanding how Korean mental health policies have been developed

and changed. The importance of cultural factors therefore should not be underestimated. To make sense of the development and impact of mental health policies in Korea an understanding is needed of the processes by which social policies are made and the cultural contexts in which policy decisions are taken.

In recent years, more cultural theorists attributed the unique pattern of the East Asian welfare state to the region's cultural values (Jones, 1990; Park, 1990). From a cultural perspective, Confucianism plays a key role in shaping political actions of East Asian political elites. Because Confucianism has influenced these elites to believe that mutual support among family members and relatives is their primary duty, they may not have developed a strong sense of public responsibility for the well-being of the general population.

White and Goodman (1999) argue that cultural explanations were utilised by political elites to rationalise their policy-making, which usually included inaction on welfare policy development. Chang (1997) shows that Korean conservative politicians and bureaucrats have been using critical Confucian views on the nuclear family – largely in order to avoid public responsibilities. It could be argued that 'Confucian' forms of government have influenced mental health policy making in Korea while there has been a recent shift away from 'social' forms of government towards neo-liberal political rationalities, strategies and technologies of rule in many Western countries.

The relationship between the individual and society is the foundation of Western community-based mental health policy. However, many have noted that Korean society is more collectivist, and while individuals are recognised, their needs are for social

groups. In this way, Korea could be argued to have done itself a disservice by looking to the West for a mental health services model to import and adapt rather than looking for an indigenous model that may be more appropriate to Korean culture.

The practice of looking outside of Korea for models to import and adapt may have worked well in economic development, but this appears bankrupt in social development, particularly in mental health, an area so intimately tied to social values, customs, and prejudices. In addition to the human suffering imposed by Korea's mental health policies, a real tragedy is that Korea has all but ignored existing native models, or the germination of new models that are at once progressive and in consonance with Korean social values.

For example, Americans have an interpersonal moral code that stresses personal freedom of choice and individual responsibility, whereas Koreans have a duty-based interpersonal moral code that emphasises mandatory responsibilities towards others. These mandates are based on one's position vis-à-vis the other person in the social and familial matrix. These core values have direct relevance to the societal position and self-evaluation of dependent disabled adults who rely on family members and others for economic sustenance and caregiving.

In collectivist culture, a shared view of reciprocal obligations may make it easier for individuals to concede impairment and to accept help from those whose roles mandate the provision of support. Tsuang and Faraore (1997) state that:

Researchers for the WHO reported that the most important cultural factor implicated in the improved outcome for patients in developing countries were: close family ties,

extended families, active participation of the family in the care of patients, and other factors which made it easier for patient, to return to their previous lives.

Lin and Kleinman (1988) also suggest that it is easier for families to be caregivers, than in traditional cultures as there is less social isolation and fewer extended human resources to buffer the family burden when compared with the burdened nuclear family in western cultures. Since Confucian values are favourable to the limited intervention principle, the government takes an active role in promoting them through the provision of social welfare. In fact, social welfare is provided to reinforce rather than replace the family in looking after its members. Instead of offering welfare benefits to relieve pressure on the family, the main direction of family services and family life education is to promote family obligation and duties.

Through my literature review I have found that relatively few resources are currently available which enable me to examine mental health programmes and policies from a comparative standpoint. Given the diversity of cultural values, political and economic structures, and social welfare and health policies around the world, it is not surprising that major differences exist between nations in the treatment they provide to the mentally ill (Benson, 1996). However, literature on comparative mental health policy mainly focuses on North American and Western European countries, which may be less relevant to East Asian countries such as Korea. Another often missed point in this literature is the importance of cultural factors on societies and social policy provision. Welfare state policies and culture are mutually interrelated in a very complex way and sometimes also contradictory ways. It could also lead to a way of analysing the impact of Confucianism on the East Asian Welfare regime. Furthermore, the fabric of the Korean welfare system is determined by a number of ideological influences. The

Confucian welfare legacy is, of course, dominated by Confucian ideology. Korean society has always emphasised dependence on family rather than the state. The values underlying the Korean welfare system are an amalgam of traditional and contemporary ideologies. The Confucian welfare legacy of family dependence rather than government dependence has been promoted by the Korean government as a means of lessening the welfare burden on the state.

3.3.2. Towards Mental Health Policy Making under the Confucian Governance

As highlighted in Chapter 2, the Confucian cultural orientation is the most influential factor affecting social policy making in Korea, although its influences has been weakened or transformed gradually along with modernisation and industrialisation in Korea. Nevertheless, Confucianism as a philosophy and vision has quite complex guiding principles and ideals of social relations and behaviour in almost every realm in Korea.

In this context, this study is expected to utilise a more insightful and comprehensive analytical framework to examine how the various cultural factors interact with economic structures and impact upon issues dealing with mental health. In doing so, this study employs the conceptual framework of ‘governmentality’, associated with the French social theorist Michel Foucault. It is said that governmentality analysis situates social and economic changes as reflecting shifts in the ‘mentality’ of government (Joyce, 2001). In this respect, it is useful to utilise the governmental analysis to comprehend Korean mental health policy making since the 1960s. By contrast with Marxist

narratives, the governmentality approach highlights not capitalism, viewed as an economic system, but the certainty of transformations in human governance in broadly liberal democratic societies. This perspective has a political focus and the capitalist market and the state are not accorded any particular explanatory, causal privilege (Stenson, 1998b).

Foucault's ideas have played an important part in shifting contemporary understanding of the state. Within social policy, 'dominant understandings of the state have in the past derived from Marxist or liberal traditions' (Watson 2000, p.71). Within Marxism the state is posited as having an independent and objective existence as a set of institutions or structures: it is seen to play a key role in organising relations of power and assumed in the last instance to act in the interest of capital, even if its role is sometimes contradictory (Gough, 1979). In liberal traditions the state is posited as the neutral arbiter of competing interests, and the welfare state is posited in similar terms.

Foucault's concern with 'how to get rid of Marxism' echoes loudly in this analysis (Curtis, 2002). The formation of the modern state can not simply be understood as the rising hegemony of an executive committee of the bourgeoisie preoccupied with the reproduction of relations of production. The modern state is a governmental state; its agencies are multiple; the technologies and tactics at its command diverse. The object of government is not first and foremost the maintenance of capitalist exploitation as classical Marxists propose (Smart, 1983) and its essential subjects are not contesting social classes. On the contrary, 'population' has come to be 'the ultimate end of government: because fundamentally, what else could its end be?'. At the same time, 'population comes to be a subject, as well as an object of government' (Curtis 2002,

pp.29-30).

3.4. Summary

This chapter has explored the explanations of mental health policy developments in Western European and North American countries, which may be less relevant to East Asian countries, such as Korea. As noted, most of comparative social policy, even comparative mental health policy, has appeared to remain substantially within Esping-Anderson's framework of welfare state regimes. Some ascertain it by applying his model to specific countries, while others try to vindicate his neglect of gender or of religion, status and ethnicity in shaping the welfare mix (Castles and Mitchell, 1993; Lewis and Ostner, 1994). Another criticism is associated with raising doubts about the applicability of his model to specific countries. For instance, East Asian countries, including Korea, though they may be a hybrid, are said to be a deviant case that can not be explained by one of his existing models (Esping-Andersen, 1999). Furthermore, another often missed point in this literature is the importance of cultural factors on societies and social policy provision (this will be discussed in Chapter 4 in more detail). Welfare state policies and culture are mutually interrelated in a very complex way and sometimes also contradictory ways.

In so doing this study employs the conceptual framework of 'governmentality', associated with the French social theorist Michel Foucault. It is said that governmentality analysis situates social and economic changes as reflecting shifts in the 'mentality' of government (Joyce, 2001). In this respect, this study will utilise

governmental analysis to comprehend Korean mental health policy making since the 1960s. This is the subject of the next chapter.

Chapter 4. Governmentality and Confucian Governance

The previous chapter examined the extent to which existing perspectives that explore mental health policy development are relevant as a theoretical rationale for Korean mental health policy making, paying attention to developing a relevant explanatory framework. In order to develop a theoretical framework for Korean mental health policy making, this study adopts 'governmentality', which has been applied by Foucauldians.

This chapter is divided into four sections including the summary, the first section outlines the concept of governmentality and different forms of government. Section two tries to explore governmentality and mental health policy in the Korean context. Section three identifies the Political Rationalities of Confucianism and its Technologies of Governance.

4.1. Governmentality and Different Forms of Government

The governmentality approach that many writers (Barry, et al., 1996; Dean, 1999; Gordon, 1991; Joyce, 2001; Light, 2001; O'Malley et al., 1997; Osborne, 1997; Rose and Miller, 1992; and Stenson, 1999) adopt is useful in understanding how power is now deployed in changing circumstances and has its origins in the later writings of Michel Foucault (1991, p.87).

Foucault only ever sketched an outline of his thoughts on governmentality – most directly in a published lecture from a programme given in 1978 (Foucault, 1991). In it, he focuses on ‘the problematics of government’. Specifically, he directs his attention to ‘the art of government’, a realm which, Foucault suggests, came to be of particular interest from the middle of the sixteenth century to the end of the eighteenth. A string of texts from this era, for Foucault, struck an implicitly ‘anti-Machiavellian’ stance in that they dwelt on the ‘art of government’ rather than dealing with strategic concerns, questions of power, or relations of force, per se. They looked, instead, to the underlying rationality of government. By examining some of this literature, and through a free-ranging process of argumentation and exposition, Foucault develops his thoughts. In essence, he marks out a domain, an area of enquiry, which looks to the manner and rationales of government, i.e., the conduct, mentalities, practices, techniques, modes, and forms of government activity (Marlow, 2002).

Foucault defined governmentality as an ‘ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this specific, albeit complex form of power which has as its target population as its principal form of knowledge, political economy, and as its essential technical means, the apparatus of security’ (Foucault 1991, p.102). In addition, he explains this in more detail as follow:

This word must be allowed the very broad meaning which it had in the sixteenth century. Government did not refer only to political structures or to the management of states; rather it designated the way in which the conduct of individuals or of groups might be directed: the government of children, of souls, of communities, of families, of the sick. I did not only cover the legitimately constituted forms of political or economic subjection, but also modes of action, more or less considered and calculated

which were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others (Foucault 1982, p.221).

The main focus of the governmentality theorists has been on uncovering the logic of government incorporated in complex interconnections between political rationalities, governmental strategies and technologies, and the assemblages of persons and locations within which they operate (Barry et. al., 1996).

In this approach, contemporary society is conceptualised as being pervaded by a system of regulation concerned with 'the conduct of conduct'. Government, for Foucault, is not merely the state apparatus, but 'political rationalities' defining issues for action and prescribing goals and values, as well as 'technologies' comprising 'the complex of mundane programmes, calculations, techniques. Documents and procedures through which authorities seek to embody and give effect to governmental ambitions' (Rose and Miller 1992, p175). Governmentality is about the disciplining and regulation of the population without direct or oppressive intervention. It is about achieving 'action at a distance', so that actors come to perceive problems in similar ways and accept responsibility for seeking ways of transforming their position themselves (Flynn, 2002).

Furthermore, Dean (1999) stresses that governmentality is not merely the exercise of authority over others but is also how we govern ourselves. The Foucauldian 'analytics of governmentality' approach is thus concerned with how we govern and how we are governed within different regimes (Dean, 1999).

Given Foucault's views about power, it is not surprising to find that he is wary about locating power in the apparatuses of the state, and indeed there are very few direct references to the state in his work. In its place he is more concerned with the construction of the 'social' and in governmentality. Foucault distinguishes between two notions. 'First, there is a notion of sovereignty, the aim of which is to maintain a territory where sovereign rule is preserved through the rule of law and the people's submission to it. Government, in contrast, is the exercise of power which concerns the realm of the social, the object of which is to manage or facilitate the best resolution of a population's needs, resources and wealth. The catalyst for the development of the art of government was the emergence of the problem of population which was constituted by the deployment of bio-power¹' (Watson 2000, p.71).

Government understood in this governmentality approach may refer to many different forms of 'the conduct of conduct', the particular objects, methods and scale of which will vary. Burchell (1996) discusses this as follows:

There may also be interconnections and continuities between these different forms of government and, in particular, between local and diverse forms of government existing at the level of interpersonal relations or institutions dispersed throughout society on the one hand, and political government as the exercise of a central, unified form of State sovereignty on the other, or between forms of government existing within micro-setting like the family or the school and the macro-political activities of government directed towards individuals as members of a population, society or nation (p.19)

¹ Bio-power is a conceptual tool that makes it possible to analyse historically how power has come to work in relation to the human body. The concept refers to the mechanism that takes the body and life as objects of intervention. Power operates on the individual body to optimise its capabilities, efficiency, usefulness, and docility. On a macroscale it also manages the biological processes of a population - births, morality, and probabilities of life. Bio-power relies on associated forms of knowledge, such as surveys, demographic studies, and public health campaigns (Chambon, et al. 1999, p270).

4.1.1. Liberal Forms of Government

The liberal forms of government emerged in the early nineteenth century. According to Foucault, it was of critical historical significance and only with the emergence of liberalism was it possible for a domain of 'society' to emerge (Foucault, 1989a). He also noted the connection between liberalism and the historical emergence of society as the political rationality:

It seems to me that at that very moment it became apparent that if one governed too much, one did not govern at all – that one provoked results contrary to those one desired. What was discovered at that time – and this was one of the great discoveries of political thought at the end of the eighteenth century – was the idea of society. That is to say, that government not only has to deal with a territory, with a domain, and with its subjects, but that it also has to deal with a complex and independent reality that has its own laws and mechanisms of disturbance. This new reality is society. From the moment that one is to manipulate a society, one cannot consider it completely penetrable by police. One must take into account what it is. It becomes necessary to reflect upon it, upon its specific characteristics, its constants and variables (Foucault 1989b, p.261)

For Burchell (1996), the forms of liberalism set out a 'schema' of the relationship between government and the governed in which individuals are identified as, on the one hand, the object and target of governmental action and, on the other hand, as in some sense the necessary (voluntary) partner or accomplice of government. He points out that:

For (early) liberalism, to govern properly involves pegging the principle for rationalizing government activity to the rationality of the free conduct of governed individual themselves. That is to say, the rational conduct of government must be intrinsically linked to the natural, private-interest-motivated conduct of free, market exchanging individuals because the rationality of these individuals' conduct is,

precisely, what enables the market to function optimally in accordance with its nature. Government cannot override the rational free conduct of governed individuals without destroying the basis of the effects it is seeking to produce (Burchell 1996, p.23)

They are seen as political constructions: differentiated spheres of social relations produced by liberal modes of government. In addition, this analysis has an explicitly normative basis, favouring the production of knowledge that will help to safeguard and extend liberal values and provide checks and balances on tyranny, which can develop from the political left as well as from the right (Stenson, 1998b).

The power of governmentality is that it allows the investigation of different aspects of liberal forms of government as essentially different aspects of the problematisation of power (Rose and Miller, 1992; Rose, 1993). The difference between this and traditional policy studies is the notion that conceptions of government and population are not fixed but are the product of the changing power/knowledge discourse in which they are embedded. For Foucault, the Western 'art' of liberal government is a dynamic, self-critical process. At its centre is the inherent tension between minimum intervention by the state and a 'will to knowledge' about populations that expands the number of the categorisations that individuals are subjected to and subjectified by, in the pursuit of the most efficient form of government.

However, the reflexive nature of liberalism as a mentality of government, continuously leads to the questioning of appropriate boundaries between the political/public domain of government activity and the non-political/private domain, the preserve of the autonomous individual. The problem for all types of liberalism is that most of the regulation of the population takes place in the non-political/private domain, particularly

within the structure of the family. It is in this context that the concept of expertise has evolved as a technology of control and surveillance so that liberal governments can regulate this private domain, 'without destroying its existence and its autonomy' (Rose and Miller 1992, p.180; Joyce 2001, p.596).

In conditions of liberalism, Foucault's prime concern was to understand how personal liberty, autonomy and choice could be reconciled with the state's need to govern. Foucault sought solutions to this, not by exposing the apparent contradictions and conflicts inherent in liberal thought, but on the contrary, by understanding liberalism as a particularly productive discourse. For Foucault, then, liberalism is concerned with trying to determine how government is possible, what it can do and what it must renounce to achieve its potential. It is thus a perpetually reflexive activity, constantly seeking to understand why it is necessary to govern and how. Foucault locates traces of this thinking in precise historical texts that contribute to a conception of liberalism, with all its compromises, hesitations and paradoxes, as a shifting and polymorphous set of possibilities (Schofield 2002, p.666).

4.1.2. The Social Logic of Government

The 'social logic' of government is a form of 'governmentality' (Stenson and Watt, 1999). This refers to the range of ways – with the censuses, studies of urban poverty and the social sciences playing a central role – in which the population is made thinkable and measurable for the purpose of government (Foucault, 1991; Barry et al., 1996). Governing in the name of the social, which is not reducible to governing the economy,

is holistic. It attempts to foster social solidarity, often at the level of the nation-state, but also at more local spatial scales, hence providing an effective underpinning for the operation of markets (Stenson, 1998a; Stenson and Watt 1999). Government is seen as operating in a range of sites beyond the confines of national and local state agencies and is rooted in political rationalities whose provenance goes back to late 19th century Europe (Gordon, 1991). Smart describes the shift noted by Foucault in the realm of the social as follow:

The emergence of the 'social' and the associated mechanisms directed towards such dimensions of population as fertility, age, health, economic activity, welfare and education, not only represent a major development or shift in the form of the exercise of power, but in addition it has produced significant changes in the nature of social relationships, and has since the mid-nineteenth century effected a particular form of cohesion or solidarity within society..... it is at the political level that the various measures and technologies of power associated with the rise of the social have had their most critical impact (Smart 1983, p.121).

The governmentality theorists' narrative about the shift away from welfarist policies and practices challenges the view that these shifts can be understood principally in terms of changes in the economy and the state (Rose and Miller, 1992).

Governing in the name of the social – which underpinned the policies of welfare states in the high period between 1945 and 1980 – attempts to foster social solidarity, hence providing an effective underpinning for the operation of markets (Rose, 1996b; Stenson, 1998b, 1999). The aims of social government include the goals and technologies of redistributive social justice, 'tutelage' of the poor into the perceived norms of acceptable citizenship (Donzelot, 1979) and the use of actuarial technologies of risk-sharing. The pool of risk-sharers ultimately encapsulates the citizens of the state and

protects against crime, unemployment, sickness, old age and the other risks associated with the minimally regulated play of market (Donzelot, 1991).

'Social' policies, operating with universalist criteria for service provision, were associated with the development of a differentiated institutional apparatus for the delivery and co-ordination of the major social services (Stenson and Watt, 1999). The social logic of government fosters the differentiation of 'social' policies and a 'social' sphere from the 'economic' sphere of economic/contractual relations. However, this should not be conceived of simply as the operation of official agencies, since the 'social' creates a field of possibilities for recipients of social services to try to set their own agendas. Moreover, differentiation of a field of 'social policy' was assisted, in part, by the academic disciplines of social policy and other social sciences that conceptualise the 'social' as a separate domain of investigation. (Crowther, 1999; Hill, 1996; Stenson, 2000).

However, writers from within the Foucauldian governmentality theorists have characterised recent governmental trends, associated with neo-liberal political rationalities, as manifestations of the death of the collectivist and universalist character of the 'social' (Stenson and Watt, 1999). Joyce has noted this recent governmental trend:

Using the conceptual framework of 'governmentality', it will be argued that one of the most important aspects of this shift is that neo-liberal forms of social policy governance re-code and re-problematise the function of the health and social care system, predominantly in terms of an economics discourse (Joyce 2001, p.595).

4.1.3. The Rise of Neo-Liberal Modes of Government

Over the past 50 years, welfare liberalism has itself come under sustained criticism by those who denounce it as undermining the very freedom that liberalism is there to guarantee. In response to this critique, liberalism is undergoing a further mutation into a distinctive form in the advanced economies of the West.

Not surprisingly, there has been considerable debate surrounding the sustainability of present levels of state provision. European governments have tended to argue for retrenchment and for the substitution of state provision by other means. (Shaw 1999a, p.362)

Within the governmentality framework, it is argued that with the rise of neo-liberal modes of government since the late 1970s, the social is now on the wane or even dying. Increasingly, social policies must be justified according to a utilitarian logic, as contributions to the more efficient operation of markets. And the tasks of government are redistributed across, and blur the boundaries between, statutory, voluntary and commercial sectors and agencies (Osborne and Gaebler, 1992). Broad inclusive, national notions of a risk-sharing collectivity give way to smaller risk-sharing collectivities (O'Malley, 1992; Stenson, 1993). Local communities are encouraged to be more self-reliant or enrolled in the tasks of government. State and local state agencies are encouraged to target their interventions more precisely towards particular 'communities', social groups and neighbourhoods. These are seen as representing high levels of criminal and other modes of social risk for themselves and for the well-being of other groups and interests (O'Malley and Palmer, 1996; Stenson, 1996, 1998a).

In its new 'advanced' or 'neo-liberal' form, liberalism no longer seeks to govern through 'society' (Schofield 2002, p.667). According to Rose, in this form it typically seeks:

To de-governmentalise the state and to de-statise practices of government, to detach the substantive authority of expertise from the apparatuses of political rule, relocating experts within a market governed by the rationalities of competition, accountability and consumer demand. It does not seek to govern through 'society' but through the regulated choices of individuals now construed as subjects of choices and aspirations to self-actualisation and self-fulfilment (Rose 1996a, p.41)

Governmentality theorists argue that policy discourse is a means through which neo-liberal rule is exercised in relation to particular 'risk' population groups (Dean, 1999; Rose, 1998). As Petersen (1997, p.194) argues, 'neo-liberalism is a form of rule which involves creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy'. Governmentality theorists argue that modern individuals are increasingly urged to consider their everyday lives and well-being in terms of a lifelong project of self improvement and lifestyle optimisation (Rose, 1999).

Furthermore, Foucault's concept of governmentality has two advantages in theoretical terms for an analysis of neo-liberalism. Lemke (2001) explains this:

Given that political leadership is only one form of government among others, first, the dividing line the liberals draw between the public and private spheres, that is the distinction between the domain of the state and that of society, itself becomes an object of study. In other words, with reference to the issues of government these differentiations are no longer treated as the basis and the limit of governmental practice, but as its instrument and effect. Second, the liberal polarity of subjectivity and power ceases to be plausible (p.201).

From the perspective of governmentality, government refers to a continuum which extends from political government right through to forms of self-regulation, namely 'technologies of the self', as Foucault calls them (Foucault, 1988).

By means of the notion of governmentality, the neo-liberal agenda for the 'withdrawal of the state' can be deciphered as a technique for government. The crisis of Keynesianism and the reduction in forms of welfare-state intervention therefore lead less to the state losing powers of regulation and control (in the sense of a zero-sum game) and can instead be construed as a reorganisation or restructuring of government techniques, shifting the regulatory competence of the state onto 'responsible' and 'rational' individuals. Neo-liberalism encourages individuals to give their lives a specific entrepreneurial form. It responds to a stronger 'demand' for individual scope for self-determination and desired autonomy by 'supplying' individuals and collectives with the responsibility of actively participating in the solution of specific matters and problems which had hitherto been the domain of state agencies specifically empowered to undertake such tasks. This participation has a 'price-tag': the individuals themselves have to assume responsibility for these activities and possible failure (Donzelot 1984, 1996; Burchell, 1991, 1996).

The theoretical strength of the concept of governmentality consists of the fact that it construes neo-liberalism not just as ideological rhetoric or as a political-economic reality, but primarily as a political project that endeavours to create a social reality that it suggests already exists. Neo-liberalism is a political rationality that tries to render the social domain economic and to link a reduction in (welfare) state services and security systems to the increasing call for 'personal responsibility' and 'self-care'. In this way,

we can decipher the neo-liberal harmony in which not only the individual body, but also collective bodies and institutions (public administrations, universities, etc.), corporations and states have to be 'lean', 'fit', 'flexible' and 'autonomous': it is a technique of power.

The analysis of governmentality not only focuses on the integral link between micro and macro-political levels (e.g. globalisation or competition for 'attractive' sites for companies and personal imperatives as regards beauty or a regimented diet), it also highlights the intimate relationship between 'ideological' and 'political-economic' agencies (e.g. the semantics of flexibility and the introduction of new structures of production). This provides an opportunity to shed sharper light on the effects neo-liberal governmentality has in terms of (self-) regulation and domination. These effects entail 'not just the simple reproduction of existing social asymmetries or their ideological obfuscation, but are the product of a re-coding of social mechanisms of exploitation and domination on the basis of a new topography of the social domain' (Lemek 2001, p.203).

4.2. Governmentality and Mental Health Policy in Korean Context

In order to analyse mental health policy making in Korea, this study will draw heavily on recent Foucauldian work on 'governmentality'. This concept will be useful in such a context because of the innovative ways in which it helps us to describe the amalgamation of an array of governmental technologies (ways or methods of intervening in the non-discursive world constructed by political rationalities) that work

across private and public boundaries to realise, or at least attempt to realise, governmental programmes (Rose, 1993). By this means, it is possible to understand the emergence in Korea of a specific governmental interest in mental health policy as characterised by certain reproductive regularities and capacities which are amenable and open to intervention. A brief genealogical approach will enable us to trace the threads of a concern with mental health policy making, its amalgamation with other governmental technologies and forms of reasoning, and eventual deployment within the context of mental health policy making.

In this connection, it could be argued that we need to understand governmentality in a number of distinct ways. I propose here to examine the application of governmentality in problematising mental health policy making in the Korean context from three fronts. First, the concept of governmentality will be used as a particular method or way of understanding the 'conduct of conduct' – 'a form of activity aiming to shape, guide or affect the conduct of some person or persons' (Burchell, et. al., 1991, p.2). Second, using the conceptual framework of 'governmentality', it could be argued that one of the most important aspects of this shift is that neo-liberal forms of social policy governance re-code and re-problematise the function of the mental health care system, predominantly in terms of an economic discourse. Finally, the government's rationale for fostering 'Confucianism' will be examined in order to look at the moral discourse on the family as it appears to have been useful in legitimating their suppression of demands for welfare programmes.

4.2.1. Forms of the Government in Korea

4.2.1.1. Developmental Authoritarian Government

The economy in Korea has largely been managed under the leadership of state entrepreneurs who have used what is popularly called 'developmental authoritarianism' to propel rapid economic growth under the slogan of 'growth first, distribution later'. By the 1980s, this 'growth first' initiative had lost most of its popular appeal in national politics, and political leaders proclaimed the goal of building a 'welfare state' by the beginning of the 21st century. At least in public policy announcements, social welfare has become a prime goal of administrative activities, supposedly linked to 'social integration and the sustenance of political order' (Chang 1997, pp.23-4).

In Korea the deterioration of social conditions following the 1997 economic crisis led to a rise in the demand for welfare services, while family ties and mutual co-operation in communities were declining. A new type of poverty has emerged among women, children, the disabled and the elderly without relatives, and within the urban areas because of the sharp decline in incomes and the fact that most of the unemployment occurred among low paid temporary workers, resulting in poverty rising substantially. At the same time, income inequalities are widening, threatening a breakdown in social cohesion. In this circumstance, the Korean government was expected to extend welfare provision for people in need. However, the government also faced some obstacles to expanding welfare programmes. The obstacles were lack of funding and resource allocation. The government pursued economic recovery and stable strategies. The government policies therefore were highly driven by economic concerns. In this respect,

it is particularly important to identify how the economic strategy constrained mental health policy decisions and the structure of mental health policy institutions.

There has been a controversy on the subject of the political influence and achievement of the New Right in shaping the pro-family moral discourses and movements in Western countries like the United Kingdom and the United States (Durham, 1993; Somerville, 1992, 1993). The political implication of the seemingly moral judgements concerning family change is not confined to those Western countries under neo-liberal rule. In Korea, moral criticisms of recent family change serve not to reverse a so-far progressive social policy regime as in Western welfare states but to dissipate the political pressure for a policy transition from economic growth-oriented state intervention to social welfare-oriented state intervention. Such political use of the moral discourse on family change is facilitated in the still strong Confucian socio-cultural environment (Chang 1997, pp.22-3).

4.2.1.2. Neo-liberal Trend in Korea

The neo-liberal 'world trend' has influenced Korea since the 1980s when the movement towards privatisation launched political debates throughout the country. Because General Chun seized power through a military coup, many people questioned the legitimacy of his government. During his authoritarian regime (1980-1987) the neo-liberal orientation seemed not to be supported by the citizenry due to the corrupt and oppressive bureaucracy of Chun's regime. Kim Young-Sam's democratically elected regime (1993-1998) pushed even more forcefully in the neo-liberal direction in an effort

to increase efficiency and economic competition. His regime stood for 'small-government' and 'productive welfare'. Neo-liberal policies were introduced in an effort to transform basic relationships between the state and the market. Deregulation sought to invigorate competition and promote market flexibility. The educational system was reformed and new management skills were advanced to lessen conflict in 'labour-capitalist' relations, promoting prudent compromise rather than hostile dispute. Public spending on social welfare programmes was reduced as government came to rely on the innovation and collective efforts of religious, civic, and volunteer groups and social purpose enterprises². The percentage of the population receiving public assistance and medical aid decreased and has continued to do so even after the economic crisis of 1997 (Kim, Y. H. 2003, pp.64-5).

Currently, there is considerable debate in Korea about how to reform social insurance, whether by increasing private investment or state responsibility. Labour and social action groups oppose neo-liberal ideas, but a high-tech economy plus the vagaries of globalisation continue to challenge social welfare reform in Korea. Since the 1990s the neo-liberal tendencies (see Table 4.1.) which have been detected in Korean policies more or less parallel the neo-liberal developments in the industrialised countries of the West (Kim, Y. H. 2003, p.65).

² Social purpose enterprises are specifically created with the thought of employing the most difficult to employ. A social purpose enterprise is a revenue generating commercial venture founded by a non-profit organisation to provide jobs and / or training opportunities to low income individuals. Sometimes these enterprises are completely sustained by market revenue and sometimes they are partly subsidised because the overall social benefits produced are sufficiently valued by the stakeholders.

Table 4.1. The Neo-liberal Tendencies in Korea

| Policies | Details | New Liberal Transformation |
|-------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Economic Policies | State involvement | Deregulation Involvement for market competition Reducing public spending Privatisation |
| | Labour-market policies | Enlargement of market flexibility |
| | Relationship between labour and capital | Changing attitude from hostile to compromising |
| Social policies | Basic orientation | Stress on 'productive welfare' policies Extension of private sectors Emphasis on the obligation of individuals and family (Citizenship) |
| | Social insurance system | Attempt at the privatisation of the 'Industrial Accident Insurance' Integration of medical and social insurance system for efficient management |

Source: Kim, Y. H., 2003.

4.2.2. Consideration of Confucianism as a political rationality

Although Confucianism is close to neo-liberalism in terms of assisting economic performance, it is clearly not the whole story. It is important to explore the differences between Confucianism and Neo-liberalism and show how it assisted the development of Korean economics and how now it may actually be hindering further welfare development. In this respect, recently Kim, Y. H. (2003) has explored the future directions for the Korean welfare system as it adjusts to economic globalisation. She

points out some similarities and differences of social rights and the obligations of citizenship between the West and Korea as follows:

One may detect some resemblance between the neo-liberal emphasis on the obligation of citizenship and the Confucianist emphasis on the obligation to care for family members. But they are two different concepts. The Korean government has not guaranteed social rights for the people due to economic striving for development. Without satisfaction of the social rights of citizenship, how can the obligation of citizenship in a competitive world be accepted and internalised by the people? Koreans have little experience with volunteerism and participation in a civil democratic society in which the citizen has both obligations and rights. Clearly more time is needed for Korea to develop an approach to social policy that mitigates the tensions between Confucian 'familism' and 'liberal' rights and obligations of citizenship (Kim, Y. 2003, p.66).

As mentioned earlier in Western society the economy is now geared towards individualisation (Beck, 2001). People are encourage to take individual responsibility for themselves and the tendency is to engage in relationships only so long as they are personally satisfying to them (though governance is trying to emphasise citizenship as a way of forwarding the importance of obligations). The individual becomes the central focus of consumption. However, this has not (at least yet) happened in Korea. This, in part, is due to the strength of Confucianism - which emphasises duties, regardless of whether they are satisfying to the individual or not - and the economy is geared towards the 'social wage'³.

³ That part of workers' means of subsistence which is provided as a free public service rather than purchased. In March 1969, the British *Daily Telegraph* said: 'The social wage in plain English means government hand-outs, the exact opposite of a wage.' Social democrats often say that the most effective way of defending and improving workers' living standards is not to award pay rises, but to increase the benefits that workers receive via state services. This, it is said, will moderate industrial conflict entailed in wage bargaining, reduce inequalities among workers and provide a "safety net" for the poor, provide services more efficiently and foster an ethos of collectivism rather than individualism. Promotion of the concept of social wage invariably means arguing against fighting for pay rises, and is based on the assumption that class struggle is a *bad thing*; better to use the democratic process to elect social democrats to government and legislate improvements in the social wage. "Social wage" fell out of use in

In addition, Western notions of citizenship around rights and obligations are being emphasised because the nature of society in the West is more individualised. Korea is not individualised (largely because of the influence of Confucianism) and consequently neo-liberal concepts around citizenship do not yet apply. It could be argued that neo-liberalism and its market rationality is preferable to Confucianism because the feminist voice is weak and women in Korea have been largely apolitical. However, women are still expected to play a central role in providing care for dependent family members. In this respect, it is more likely to be convinced by neo-liberal minded economists and politicians that the government's rationale for fostering Confucian views on family responsibility contribute to reducing state intervention into welfare provisions for dependant people. Furthermore, 'Confucian governmentality' could be utilised by policy makers as a rationale for their policy making and to cope with new challenges: 'rapid transition to post-industrialism, increasing globalisation, sweeping changes in demography and social relations' (Ferrer and Rhodes 2000, p.1).

4.3. Confucian Governance: the Political Rationalities of Confucianism and its Technologies of Governance

The government's rationale for fostering 'Confucianism' and family responsibility appears to be disingenuous. At times, Korea's political leaders are likely to be convinced by their own rhetoric that supportive income and social services would

the latter part of the 20th century, as social democratic parties around the world were engaged in running down health services and pensions while unions were bargaining for employer contributions to health insurance and superannuation funds (<http://www.marxists.org/glossary/terms/s/o.htm>)

undermine the Confucian tradition of the family caring for dependant people. The political-economic drive for low income taxes and low taxes on equity transactions, combined with subsidies and incentives to encourage exports plus a substantial commitment to the military budget, leaves few resources available for social services. The government is thus using the Confucian ethic as 'a rationale for its laissez-faire approach to the problems posed by dependant people' (Palley 1992, p.801). Weiming (2000) points out that 'East Asian modernity under the influence of Confucian traditions presents a coherent social vision with at least six salient features' (pp.205-206):

- (a) Government leadership in a market economy.
- (b) Organic solidarity resulting from humane rites of interaction.
- (c) The Family as the basic unit of society.
- (d) A civil society, which draws its inner strength from the dynamic interplay between the family and the state.
- (e) Education.
- (f) Self-cultivation as the common root of the regulation of the family, of governance through the state and from the stability provided by peace.

Furthermore, the doctrines of Confucianism advocate 'a centralised benevolent form of monarchy as the only legitimate form of government and stress the absolute subordination of the people to their government' (Tang 2000, p. 51).

4.3.1. The Government's Rationale for Fostering 'Confucianism': the Political Rationalities of Confucianism

In Korean history, Confucianist ideology exerted a hegemonic influence around the mid-seventeenth century. This was an era when Korean (the Chosun) scholars even excelled Chinese scholars in revitalising and refining old Confucian philosophy into a

comprehensive set of norms, laws and customs for prescribing political rule and social relationships. Under Confucianism, the patriarchal family played a central role in social control, political integration and welfare provision (Cho, 1991). When Korean society entered the modern industrial era after successive colonial encroachments, indigenous elites made no serious attempt to eradicate the Confucian tradition of family-centred life. In fact, Confucian values and attitudes were incorporated into public education and political discourse as a legitimate cultural heritage. In Korean society today, people are under strong moral and, sometimes, political pressure to sacrifice their individual interests for unconditional family unity, to confine familial problems within the family, and to abstain from resorting to social or governmental measures in solving familial needs (Kim, 1990; Chung, 1991).

Since the 1960s, Korea has shifted from being a mainly agrarian, rural society to an urbanised and industrial, newly modernising one. Of the Asian modernised or modernising societies that have Confucian ethical heritages, it appears that Korea is one of the most closely bound to the relational aspects of this heritage (Kihl, 1994). Modernisation, accompanied by demographic changes, urbanisation, and industrialisation, have contributed to changes in Korea's family structure. Traditionally, the Confucian ethical and relational system holds the eldest son to be responsible for the care of his elderly parents, although in modern Korea it is possible for another son to assume this care-giving role. The second cardinal virtue of Confucianism requires the obedience of the son to the father and the third requires the obedience of the wife to the husband. Moreover, the political structure's emphasis on economic development makes it difficult to moderate any social stress factors through the development of a social welfare infrastructure. The previous Korean governments have followed a political-

economic model that emphasises stimulation of economic growth and industrial development (Kwon, 1995, 1999; Joo, 1999a, 1999b; Shin, 2000b).

It has been Korea's deliberate governmental strategy not to develop a supporting social infrastructure or a modern welfare state package of social services and income policies and programmes that would assist the elderly and their informal caregivers. It has been the reason for the lack of government action in the face of the increasing imperatives of demography, as well as segmentation and nuclearisation of families accompanying modernisation and urbanisation (Chang, 1997). That is to say, Confucianism could be regarded as 'governmentality' in terms of political rationalities, strategies and technologies of rule in order to foster the family responsibility for their dependent members and avoid state responsibility for providing welfare services.

4.3.1.1. Korean Pattern of Confucian Ideals, Authority and Personality

Confucianism as an established state ideology existed until the early twentieth century. Even today, family relationships, political attitudes, ways of problem solving and many other aspects of Korean life reveal the imprint of the Confucian tradition (McCune, 1959; Reeve, 1963; Osgood, 1951; Hahm, 1967; Henderson, 1968; Yang and Henderson, 1958, 1959). As the unchallenged, uninterrupted socio-political ideology of historic Korea, Confucianism was the single greatest influence on the Korean political culture and provided the view of the universe in which Korean society and politics operated (Kihl, 1994).

Confucian precepts represented by the Confucian Classics were major objects of study by traditional Korean scholars and valued for both their practical governmental wisdom and their philosophy of life in general. The 'formalities' of early Korean bureaucracy were based on Chinese Confucian models (Kim and Kim, 1997).

In particular, Chu Hsi Confucianism strongly appealed to Koryo scholar-officials as it was not abstract or speculative metaphysics but rather practical, moral, and educational in its institutional applications and in its emphasis on the formalities of ceremony, etiquette, rank and hierarchical social structure (Kim and Kim, 1997).

Chu Hsi Confucianism offered an ideological/cultural rationale for a centralised bureaucracy and an elitist intellectual political conservatism. In short, Confucianism became the official creed of the government. This development was a remarkable event in Korean history. As a state ideology Confucianism was the chief intellectual frame of thought throughout the entire Chosun dynasty (Kim and Kim, 1997).

With extreme literalism, the doctrines of Chu Hsi Confucianism advocated a centralised benevolent form of monarchy as the only legitimate form of moral government and thus contributed greatly to the foundation of a highly centralised autocracy. At various times during this dynasty, various school of Chosun Confucianism had controversies over divergent views of the nature of rules governing ethics and the practice and strategy of administration (Yang and Henderson, 1958)).

The school of Li (also known as the *Songni Hakpa*, the 'natural-law' school) provided the Confucian political system with moral authority, and ethical legitimacy.

Government was the final authority that could represent the Supreme Ultimate (*Li*) truth in the real world. And naturally, government had Benevolence (*In*), the highest virtue and the supreme quality of *Li*. The 'final cause' of politics belonged to the authoritative monarch (Kim and Kim, 1997).

The school of Rites (*Ye Hakpa*) emphasised an unusual degree of strictness in formal ritualism which became the most striking characteristic of the Chosun social system, i.e., highly complex court ceremonies, official and personal behaviour. The observance of *Ye*, rites or etiquette and ceremony had a significant impact both on the social conduct of the Korean people and on the development of Korean politics and administration (Kim and Kim, 1997).

These Confucian Schools were, however, closely associated with Chosun political factionalism. Scholars and officials quarrelled over controversial questions of legitimacy, dynastic succession and court procedures.

Rival group competition for the power of government followed the division into philosophical schools of thought and the so-called 'four factions' of 'four colours' (*Sasack*) persisted as the principle factions in Chosun politics until 1910. These rivals fought the philosophical validity of each other in a long, bloody, factional struggle.

The effect of Confucianism on the popular psychology of the Korean people can be characterised as follows: (a) hierarchical view of life; (b) authoritarianism on the part of the ruling class; (c) a corresponding 'submissiveness' on the part of the ruled; (d) a 'face/or status-oriented' consciousness; and (e) the well-ordered family (Yun, 1970).

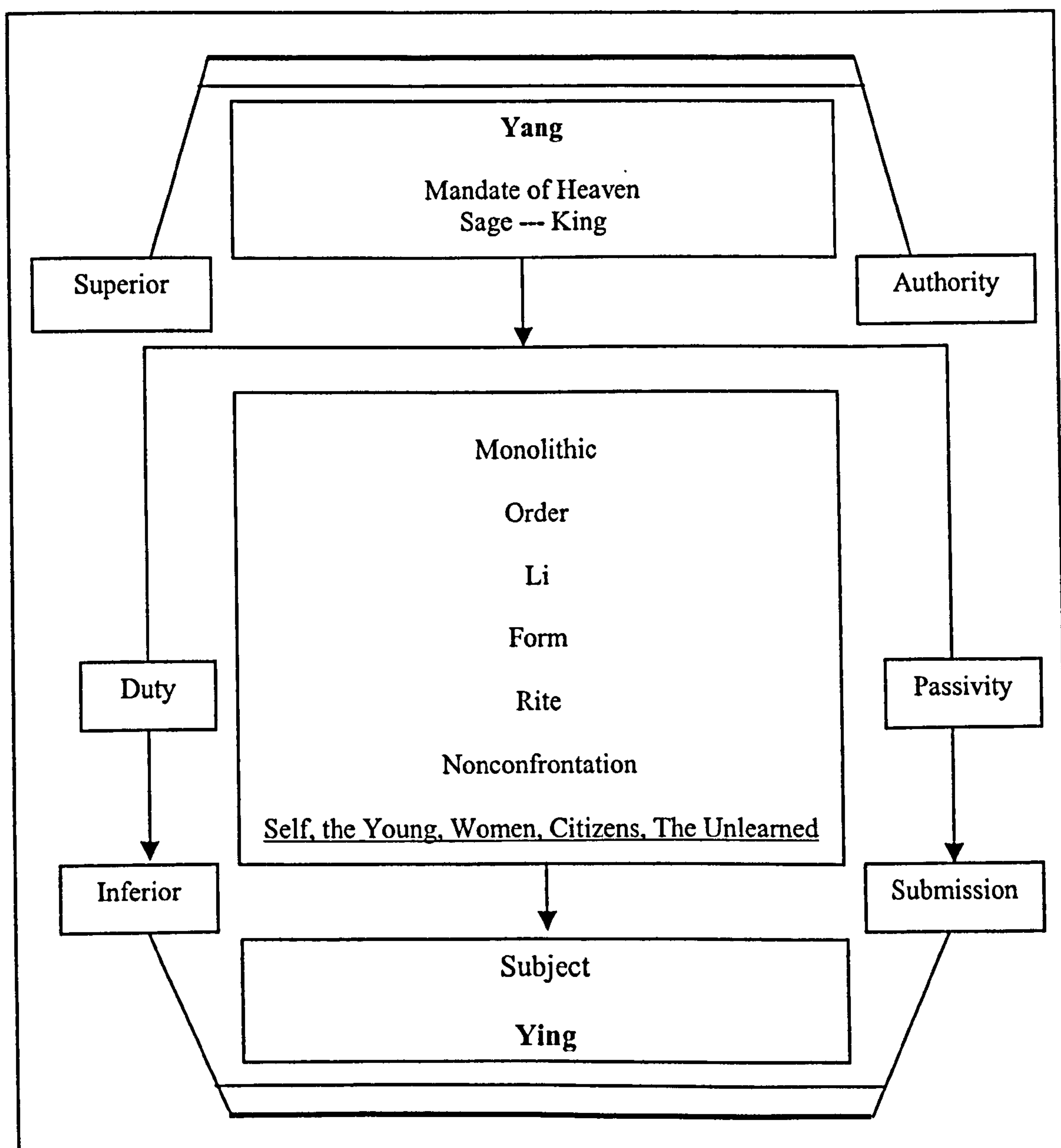
Hierarchy and authority are at the heart of Confucian ethics and represent a vertical order, not horizontal. The implicit values in Confucianist politics are those of harmony, stability, and hierarchy based on the absolute authority of a well-ordered hierarchy (Wright, 1962), the Ultimate *Li* – in the codified rules of social behavior, Confucian authority finds its perfect embodiment in the well-ordered patriarchal family, that is, the microcosm of the socio-political order that ideally prevails in both the state and society (Kim and Kim, 1997).

In the Confucian family, adults learn how to manage private affairs and to direct others for the common good while the young learn to obey their parents and to play their proper roles in the kinship hierarchy. The former is a model for the wise ruler while the latter is the model for properly submissive subjects. *Li* reflects the very structural characteristics of Confucian authority. Wright states that ‘the *Li*, spread by fathers, village elders, and government officials, and supplemented by the discipline of ordered family life, would in turn foster social virtues: filial submission, brotherliness, right-consciousness, good faith, and loyalty’ (Wright 1962, p.7). Both structurally and ideologically, Confucian authority creates controlling forces of governing power by denying the sentiment of aggression (Pye, 1970). Lucian Pye (1970) points out that Confucian hierarchy was uniquely designed to repress all manifestations of the basic human aggression drive.

The following Figure 4.1 illustrates Confucian authority and its nature of repressing human aggression. Attitudes (or sentiments) toward authority are determined by the cosmic-ethical order. The vertical relationships of hierarchy and authority are reducible

to the dichotomised relation between 'superior' and 'inferior'. The King, the man, the father, the elder, the learned, the public officials constitute superior poles, in contrast to the corresponding inferiors, the subjects, the women, the children, the young, the unlearned, and the private citizen. The morally 'qualified' or 'perfected' ones (on the top line in Figure 4.1) are entitled to manage the community affairs of the family, society, and state.

Figure 4.1. Confucian Moral Authority



Source: Kim and Kim (1998)

Submission is stressed and, in practice if not in theory, it takes the form of unquestioning obedience and conformity on the part of the inferior (on the bottom line in Figure 4.1) towards the superior. The nature of non-confrontation between the two poles does not allow for the legitimacy of aggressive sentiments against superior authority.

Confucian hierarchy is governed by inherited ascribed status, not by achievement. The biological fact of individual status cannot excuse him from confronting the appropriate behaviour patterns. Passivity is a virtue in the Confucian worldview and since the system is monolithic, the individual's only possible response to his superior is to submit to his authority. In short, submission to authority is the cardinal virtue in the Confucian system.

4.3.1.2. A Philosophy of Maintaining Social Order

The class of '*yangban*' were well acquainted with the Confucian scriptures and were supposed to master the doctrines of Confucius, Mencius, and other Confucian scholars. They especially appreciated Chu Hsi's doctrines, which emphasise ritual courtesy. They also respected the idea of benevolence, the supreme virtue of Confucianism, and cherished highly its three cardinal principles and five moral rules, all of which foster authoritarian human relationships.

Confucianism, of course, is useful for maintaining social order, but not for bringing about material progress. Under the ethics of Confucianism, it is very difficult to introduce or create new ideas in opposition to traditional ones. Confucianism was the philosophy of the literati-officials who ruled the people, therefore, they devalued manual labour, technical matters, and practical things. They had little interest in labour and production, and were concerned only with the proper way of behaviour in social life. Confucianism regulated every relationship in society, and it taught that there was order between father and son, husband and wife, older and younger, and king and servant. According to Confucian teachings, the former is always superior to the latter. No question to this rule was permitted and obedience was required. This rule is called 'ye' and to be 'a man without ye' was the worst criticism in traditional Korea. This is why conformity of behaviour and obedience was highly valued in the Chosun dynasty. Anyone showing incongruent behaviour with others began to feel insecure and in order not to be a social outcast, paying close attention to others' conduct was essential. Others' opinions were always given precedence over one's desires and needs. Thus, for mere decency's sake, the people of the *yangban* class pretended they had just eaten when they were starving, and to show it, they often picked their teeth with a toothpick. In a word, traditional Koreans were extremely sensitive to other people's criticism, and relied heavily on external sanctions for 'good' behaviour. For this reason, according to Ruth Benedict's definition in 'The Chrysanthemum and the Sword (1946)', Korea also belongs to the shame culture like Japan.

This trait is still prevalent in Korean society, and it is reflected in words like '*chemyen*' and '*nunchi*' (Kim, 1987). *Chemyen* is similar to face, honour or decency, and *nunchi* means an eye for social situations. Korean people frequently use words like 'to save

one's *chemyen*' or 'in spite of *chemyen*', and they also praise a man who is good at reading others' minds as 'a man with *nunchi*'. These terms show the extent to which Koreans are conscious of other people's perceptions of them.

All in all the basis of Confucianism was to achieve the goal of social harmony by allocating a place to everyone in society at all levels, with applicable rules of behaviour. So even if Confucianism as a philosophy was mostly a matter of concern for the male elite, everybody was supposed to learn the tenets of social behaviour with the main purpose of maintaining the social order.

4.3.1.3. Moral Education as a Tool of Fostering Confucianism

As mentioned in Chapter 2, there has been an increasing awareness of the need to re-emphasise traditional moral values and the importance of moral education owing to the growing concern over the weakening traditional values of family obligation. Moral education can be perceived of as a pure ideological weapon used by a government to discipline the population. In this respect, it could be argued that Confucianism was developed as a tool, a moral precept and ethical ideology for the government to use. In Confucian education the principle of government is to refine the hierarchical, paternalistic systems already found in the family – and clan – oriented traditional society (Helgesen, 1998). Confucianism emphasised that 'rulers should take the ideal father as their model, and subjects should similarly think of themselves as dutiful children' (Pye 1985, p.73). Compared to the European industrialisation period, the process of Korea has been extremely rapid. Accordingly, traditional society was given

very little time to adjust, so, in the midst of a fundamental change of the population's environment, the establishment of a firm cultural platform became imperative. Successive governments lack of political and moral legitimation has been another important but implicit reason for promoting moral education. Yet another reason for emphasising Korean values and norms has been the growing problem of how to relate to the impact of Western culture (Helgesen, 1998).

4.3.2. Welfare Familism as a Technology of Confucian Governance

As widely realised, analysing state policies, including mental health policy, in East Asian countries cannot be grasped properly without taking the Confucian cultural orientation into consideration, although its influence has been weakened or transformed gradually along with modernisation and industrialisation in Korea.

The Confucian Family Ideology: 'Familism' is clearly depicted in Confucius teaching (Lee, M. Y. 2000, p.60), 'The ideal whole and nothing more than a family': the family and kinship systems are the basic unit and foundation of the society. Therefore, an individual is merely a member of the family unit, with a paramount duty to follow the values and roles socially prescribed in Confucian countries such as China, Korea and Taiwan. According to Yang (1988, p.97; quoted in Chen, 2000, p.41; see also Rozman, 1991; Gelb and Palley, 1995), familism is 'a set of values and their associated attitudes, beliefs and behaviour norms that are family dominated in the sense that people holding these values adopt the family as the basic social unit, not the individual. The major goal underlying these values is to maintain the well-being and the continuation of the

family'. Here the Confucian family has the following characteristics (Chang, 1976, p.44; quoted in Chen, 2000, pp.41-42).

- (a) The family is under paternal domination. The family follows the father's name, and the father has superior power inside and outside the family.
- (b) There is a preference for the extended family where more than two generations live together.
- (c) The family is an economic unit. Family members work together or independently to maintain the family economy.
- (d) Obedience is emphasised within the family. The younger members should respect their elders; children should take care of their parents.
- (e) Women's status is inferior to men's.

Furthermore, Confucianism in Korea to a large extent regulates human behaviour, regardless of people's knowledge about this particular philosophy and its moral guidelines (Helgesen, 1998).

4.3.2.1. The Family Orientation and the Concept of '*Hyo*'

Confucian teachings contain the idea of a patriarchal family system in which the father has great authority. They teach the importance of the family and clan as an in-group, the continuation of the family through the male line, sex role segregation, and ancestor worship. Thus, in Confucianism filial piety – namely, '*hyo*' – is regarded as supreme in human morality and as the prototype of all possible interpersonal relationships. Respect for the ancestors is practised through ancestor worship. Descendants are required to adore the virtue of their ancestors and to cherish the traditions of the family. Ancestors within four generations are worshipped and strong kinship unity has to be maintained.

Hyo, therefore, is constantly emphasised in that the offspring is not an independent being, and an ancestor's benediction is necessary for the well-being of descendants. Consequently, the type of relationship which is embodied in *hyo* is obedience and dependence upon the parents and the family.

Confucian teachings on filial piety have deep roots in the lives and thoughts of the Korean people. Just as the fundamental ideas of Christianity imbue all aspects of life in the West, even in this post-Christian age, so the principle of filial piety reaches into the very corners of Korean daily life, even amongst those who do not give it conscious thought or attention. Koreans have traditionally taught that children must revere and obey their parents and that children should be responsible for their parents in their parents' old age. This process goes on today, though it may be to a lesser degree than in the past.

The Filial Piety Prize System may be a representative example of the Korean government's attempts to encourage a sense of family responsibility for the care of older people in modern Korean society. This system was established in 1973 and is maintained by the Ministry of Health and Welfare. The prize is awarded as one of the major events of the Week of Respect for the Elderly, held in May each year.

4.3.2.2. Family Obligation and Families as a Social Policy Resources

The extent to which Confucianism has affected the welfare system in East Asian Countries, including Korea, needs further study and is not the focus of this thesis.

However, it can be argued that Confucian traditions have had a major influence on people's thoughts and actions in Korea. That is to say, it can be assumed that Confucianism has affected Korean society in general, which may include welfare policy making. Through the emphasis on strong familism and Confucian virtue (e.g. filial piety⁴), families and individuals in Korea (women in particular – considering the fact that most caregivers are women), carry huge responsibility for the care of children and the elderly (parents-in-law in particular). In Korean welfare provision, women are considered as the main carers, for example, nursing/caring leave systems for family members (children, parents) show that these are considered as a woman's job, and are available for women workers.

Traditionally as the agents of welfare, families are ranked first as the providers of an individual's welfare. However, families' capacities to act as welfare providers vary. When this capacity decreases significantly, it creates demands for statutory welfare policy making; and vice versa, if the families have the capacity to guarantee the family members' welfare well, the functional demand for the state's policy making would only be weak.

⁴ A major principle of Confucianism is filial piety. This notion defines specific rules of conduct in social relationships and places great importance on the family. Several key concepts follow from the principle of filial piety: 1) Family roles are highly structured, hierarchical, male-dominated, and parentally oriented; 2) The welfare and integrity of the family are of great importance. The individual is expected to submerge or repress emotions, desires, behaviours, and individual goals to further the family welfare and to maintain its reputation. The individual is obligated to save face so as to not bring shame onto the family. The incentive, therefore, is to keep problems within the family; 3) Interdependency is valued and stems from the strong sense of obligations to the family. This concept influences relationships among family members. The family provides support and assistance for each individual member; in turn, individual members provide support and assistance for the entire family. These relationship, interactions, and obligations are lifelong; and the goal of individual members is not necessarily autonomy and independence. This concept is critical to understanding Asian families, and service providers should avoid applying Western labels such as "co-dependency" and "enmeshment" when observing normal family functioning dictated by cultural values and beliefs.

In the United Kingdom, one 'other means' which has been adopted is to shift responsibility for care on to families as a primary provider of welfare. An example of this is the development of community care policies (cf. NHS and Community Care Act 1990). The development of these in recent years has firmly located the family at their hub. Indeed, although the idea of 'community' – encompassing family, friends and neighbours, backed up by statutory support – has achieved political consensus across most political parties in Europe, there is little agreement upon what this actually means in practice for the statutory services (Shaw 1999a). This inevitably puts the emphasis upon families:

Whatever level of public expenditure proves practicable and however it is distributed, the primary sources of support and care are informal and voluntary. These springs from personal ties of kinship, friendship, and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain and where necessary develop – but never replace – such support and care. Care in the community must increasingly mean care by the community. (Wicks 1991, p.173).

The family has long had a welfare role. Families can provide a means of redistributing income from those who earn to those who do not by ensuring that each family member is housed, fed and clothed. Children are reared within families and both minor illness and long-term disability are also usually cared for at home. Of course, whilst economists have used the family as a basic unit of analysis, it is individuals within families who actually produce welfare. In terms of the production of welfare, it is chiefly women who carry out the tasks and services associated with catering for the human needs within the family. One of the important consequences of the development of a welfare state is the move of many welfare tasks out of the home and into the public arena (Shaw, 1999a).

Changing family patterns in the United Kingdom also affect the dependent population in that whereas in previous generations there would have been three or four children to share the care of elderly parents, in future there will only be one or two. The increasing trends in divorce (1 in 4 marriages currently end in divorce) and marriage may result in the blurring of family ties: thus the responsibility for elderly relations may not be as clear cut or easy to meet. The nature of work has changed and family members may have to move away from the 'extended family' locality to find employment. As families become more dispersed 'crisis support' and the welfare role they can play may diminish. The increase in single-parent families may reduce the amount of time spent caring for elderly relatives, especially as income is likely to be low for these families (Shaw, 1999a).

The family provides a very important welfare resource, but the nature of 'the family' is changing and the amount of welfare it can be expected to provide certainly has its limits, which are likely to contract rather than expand in the future. Cultural theorists argue that, because of increasing individualisation, intimate relationships are changing away from the institution of marriage, with its structures of age and gender and towards the individually chosen relationship which can be broken when it ceases to satisfy (Giddens, 1992).

In Korea there are also signs of the undermining of the traditional basis of family life. The increasing divorce rate is one indicator. The crude divorce rate in Korea increased from 0.5% in 1975 to 2.5% in 2000 (National Statistical Office, 2002). As the nuclear family is dominant, the extended family makes up only a small share of the total in

Korea. In 2000, only 8.2% of all private households in Korea consisted of three generations (National Statistical Office, 2002). However, the idea of 'family' and its associated norms has not significantly changed. The values of marriage are well anchored socially, and in a Korean survey only 0.2% of the unmarried interviewees expressed a decision to remain single (Korean Women's Development Institute, 2001). Cohabitation in Confucian Korea is not popular and is still socially and morally stigmatised.

The Confucian Korean family still regards children as private assets, or as the future protectors of family interests. Parents make efforts to get their children closely attached to them, and the parental relationship is 'cultivated' with little regard to democratic values. The family's affairs are largely presumed to be a private family matter, which again discourages the production of a public and statutory family (welfare) policy. The ethos of family reliance is nourished also by the Confucian Korean state. The conservative governments in Confucian Korea tend to load more of the welfare burden onto the shoulders of families. Aiming at 'empowering' the family agent, various policy measures are adopted in Confucian Korea. It is clear that in Confucian Korea, the strategy of ensuring the best interest of women and children is mainly carried out through social control and the maintenance of family stability, and not so much through public benefits or the mechanism of income distribution.

4.3.2.3. Women's Role in Confucian Korean Family

There have been changes in Korean society in terms of increasing women's participation in the labour market – married women in particular. Progress has been made in introducing equal rights for women, increasing the number of feminist movement groups, and international organisations have had an impact on improving women's rights. It is certainly the case that Korean society has changed since industrialisation and globalisation, which have affected the increasing number of working women in the labour market. Increasing women's participation in the labour market and feminist activities have influenced women's rights, and the introduction of social policy for working women is a good example of this (e.g. child care provision etc.). However, Confucian ideas on women, such as women's nature of inferiority (Yin), women's submission to all men in the family, femininity, modesty and passivity still remain strong in Korean society. These ideas are also deeply entrenched in the 'psychi' of Korean women, as well as men. Although industrialisation has affected women's status in Korea, through increasing the numbers of working women, under the government policy of 'growth first, distribution later', both male and female workers have had to endure comparably low wages (Sung, 2002).

However, female workers are significantly more disadvantaged than male workers, when the data are broken down according to sex (Bello and Rosenfeld, 1992). In 1998, after the economic crisis, unemployment rates of both men and women in Korea increased. Although the increasing number of unemployed in Korea is not only a problem for female workers, there is a tendency for employers to make female workers resign first, rather than male workers (Park, T. W., 1999). This can be related to the

Confucian traditional ideology in Korean society that women belong to home and family work, and men belong to outside (paid) work, although there are Western similarities here.

According to Lee (1997), although rapid industrialisation from the 1960s has provided educational and job opportunities for women, Korean women are strongly bound by Confucian doctrines. Therefore, women tend to turn to marriage for their lifetime career because marriage is the main way for women to secure material resources and to obtain adult status. Confucian doctrines have emphasised women's simplicity and domesticity. Thus, women with little experience of the competitive and aggressive aspects of the industrial world will be highly valued in marriage markets (Lee, 1997). Kim, D. (1991) mentioned that women's virtue in Confucianism has prevented women from having jobs and social activities. Such Confucian ideas have had an impact on the system of Korean society as well as on people's minds.

Therefore, women are seen as second earners and their role in the labour market is considered as supplementary, although women's economic activity has increased rapidly since the 1960s (Kim, D., 1991). Although the numbers of working women (including married women) are increasing, since industrialisation in Korea, the Confucian ideas on women as inferior to men which lead to the women's subordination to men still remain both in the workplace and in the family. In terms of the family, it seems that Confucian traditions are more prevalent than in the workplace. The woman's role as daughter-in-law in a Confucian Korean family is still emphasised. Thus, women's responsibility for families-in-law in general (parents-in-law in particular) is considered more important than for their own family (Sung 2002, pp.58-9).

Furthermore, women in Confucian Korea are less active in public life. There are few female politicians and their political attitude is generally conservative. Women in Confucian Korea have been largely apolitical; the feminist voice is weak as is gender politics. Domestic work and childcare are regarded mainly as the duty of women, and most women subordinate their own interests to the interests of the family and spouse. Women's legal and economic conditions have improved significantly compared with the past, but changes in everyday life appear to be less dramatic (Lin and Rantalaaho, 2003). Many women agree with such life ideology where they take care of the reproductive work and let their husbands concentrate on career advancement. Thus, despite the mass media's frequent portrayal of women's liberation in Confucian Korea, following the rhetoric of 'development', this image does not give a picture of social reality. Thus, as welfare providers, women who act more as family agents (as mothers, household administrators, family budget managers, helpers for the sick and elderly, as well as income earners) than as social citizens can produce only rare and weak initiatives for developing social welfare policies for women, and accordingly the social pressure imposed on the state's welfare policy making for women remains weak (Lin and Rantalaaho 2003, p.10).

4.4. Summary

This chapter has highlighted the way in which there is an increasing interest among academics in the conceptual framework of 'governmentality' associated with Michel Foucault. Also the meaning of 'governmentality' has been explored to examine its

usefulness in understanding mental health policy making in Korea. And the government's rationale for fostering 'Confucianism' has been examined. Through this chapter, this study provides a new comparative dimension to this stream of discourse with its particular reference to the Confucian Korean example. Paternalistic, patriarchal, familistic, masculine, and authoritarian society – all of these determine the orientation of social policy making in the Confucian Korean state.

The future course of social policy must take account Korea's unique cultural characteristics as the traditional Confucian values of 'familism' are somewhat in conflict with the welfare state's basic mission of social care and protection. As in most East Asian countries, Korea has a strong network of family members. It is taken for granted that family members will care for their kin. There is little expectation that the government or third parties are obliged to address family needs and, hence, limited public pressure for the development of social policy. In Confucianism every detail of family life is private. The solution to any kind of problem within a family rests with the patriarchal figure, the father, who has total responsibility. Indeed, this family value inhibits government intervention, even in drastically needy cases. Koreans have little expectation of receiving publicly sponsored social care or financial aid as a 'social right'. Although Korea is in many ways a post-modern society with professional skills and high technologies, the Korean family value orientation remains tied to the roots of an agricultural society. Korean 'familism' therefore has become an obstacle in some ways to developing a welfare state. It could be argued that the government's rationale for fostering Confucian views on family responsibility contribute to reducing state intervention into welfare provisions for dependant people. Furthermore, 'Confucian

governmentality' could be utilised by policy makers as a rationale for their policy making.

In the following four chapters, the development of the mental health policy in Korea is discussed in terms of both cultural and structural factors, in relation to the emergence of mental health problems and the subsequent policy response. In particular, Chapter 5 and 6 elaborate on these themes in relation to the history of Confucianism as a rationality of governance. How has the Korean welfare regime responded to the social problem since the 1960s? Also Chapter 5 and 6 answers the question in relation to the basic assumption of social provision on which the Korean welfare regime is based: minimum state responsibility and maximum family responsibility. What draws our attention here is the contradictory relationship between the basic logic for social provision – minimum state responsibility – and the policy promises – active state intervention. Under the circumstances, in Chapter 5 and 6, the underlying assumptions of social welfare provision in the Korean welfare regime are explored, paying particular attention to the unique features which distinguish the Korean welfare regime from Western welfare regimes.

Chapter 5. Social Policy Responses under the Confucian Governance I: Industrialisation and its Impact 1962-1997

As seen in the history of the Western welfare state, the growth of capitalism and mass democracy are important historical forces behind the emergence of the welfare state in Western societies. Also, as the degree and the method of responsibility for meeting social needs varies from country to country, the historical and socio-cultural conditions are important in determining the particular shape of their social welfare systems (Sherer 1987). As noted, unlike other advanced countries across Western Europe and North America, Korea has experienced considerable social and economic changes (industrialisation and urbanisation) over a very short period of time.

However, why then has there been very slow progress in welfare-state-building compared to western societies where capitalist development had been intertwined with huge public spending on welfare state programmes and a comprehensive protection of citizens from fluctuations of the market economy in the twentieth century?

The thrust of this chapter is on the policy responses to perceived social problems and the way in which other social problems are individualised within families. These policies are informed and shaped by Korean politics and culture. In order to clarify the policy direction which has primarily influenced mental health policy making, actual welfare development in Korea is perhaps best explored, first, by examining the period

leading up to the economic crisis in 1997, in this chapter, second, by examining the period following that crisis in the following chapter.

This chapter is divided into four sections including the summary. The first section examines industrialisation and social changes, which greatly affected Korean society. Section two tries to explore the policy response of the government during the industrialisation period in order to clarify the policy direction which was the primary influence on mental health policy-making. Section three identifies the characteristics of the Korean welfare system informed and shaped by Korean politics and culture prior to the economic crisis of 1997.

5.1. Industrialisation and Social Changes

One of the key elements structuring policy development in Korea was the country's rapid economic growth. The scale of growth in the thirty years up to the late 1990s was quite remarkable - the miracle of the Korean economy – based especially on exports. This rapid economic growth also went hand in hand with massive changes in industrial structure within the country. The agricultural and fishery sector, which in 1963 employed 63.1 per cent of the total workforce, employed only 12.5 per cent in 1995, 23.5 per cent were working in the manufacturing industry, and 25 per cent in the service industry (MoHW, 1996).

As a result of these changes, many people moved from rural to urban areas, where a lot of large-scale firms were founded. This has also resulted in major changes to family

structure, with urban dwellers experiencing different family types to those of their parents, in rural districts. There has been a decline in the prevalence of traditional, three generations, Korean families, which in tandem with the decline in fertility has resulted in an overall fall in family sizes. The three-generation family type used to be 26.9 per cent of all types in 1960, but has declined to 8.2 per cent in 1997. On the other hand, the nuclear family type and single-unit family is on the rise. The average number in a family was about 5 until the 1980s, but had been reduced to 3.12 by 1997.

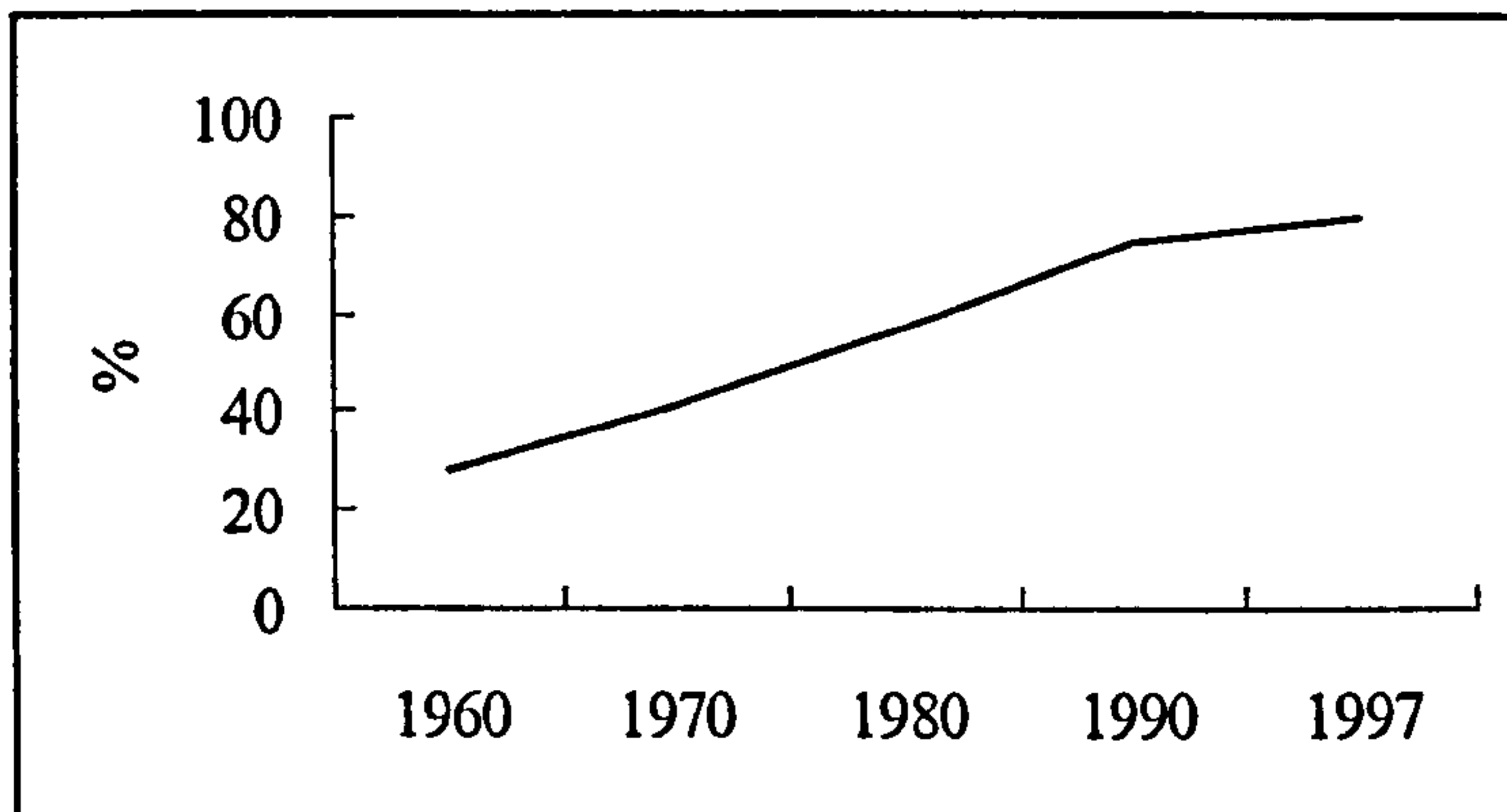
These changes altered the need for social security, which must now accommodate modern urban life rather than an agricultural rural life. People living in cities no longer expect to rely on the traditional family care and support when in need; for example child welfare provision by the state has begun to grow. The economic growth which Korea experienced during the period of urbanisation made it possible to afford to fund these welfare costs, and this has resulted in massive changes in social policy over the last forty years. But the journey to a welfare state was not a painless one. It took a long time for Korea to create a modern welfare system, and the country is still facing some difficulties as a result of both internal and external pressures. This was especially the case after the late 1990s when the growth rate declined and government budgetary restraint reached crisis levels.

5.1.1. Urbanisation

In the 1960s, Korea had a largely agrarian economy with less than one third of the population living in urban areas. This changed very quickly during the 1970s and 1980s

during a period of rapid industrialisation. As can be seen from Figure 5.1, the urban population rose from 28 percent in 1960 to 79.6 per cent in 1997 and this trend is still increasing (National Statistical Office, 1998).

Figure 5.1. The Trend towards Urbanisation



Source: NSO, *Annual Report on the Vital Statistics*, Seoul, Korea, NSO, *Various Years*.

This move of the population away from the land and towards urban and industrial centres has meant changes in family structure. In the 1960s the majority of the population lived in an extended family network. In line with Confucian philosophy the eldest son in the family was responsible for its dependants, and the family as a whole supported the welfare of its members. However, urbanisation also marked a shift away from the extended and towards a nuclear family system. The pressure on housing in industrial centres meant that often those of non-economic age and dependant had to remain in the rural environment. It has been noted before that industrialisation changes family structure in this way (Goode, 1970) and the nuclear family will be the 'normal' family pattern in Korea in the foreseeable future. However, living close to relatives is, as will be discussed later, an often necessary arrangement. This has been equated to the

European idea of 'intimacy at a distance' (Rosenmayer and Kockeis, 1963). Certainly the forces of modernity are strong.

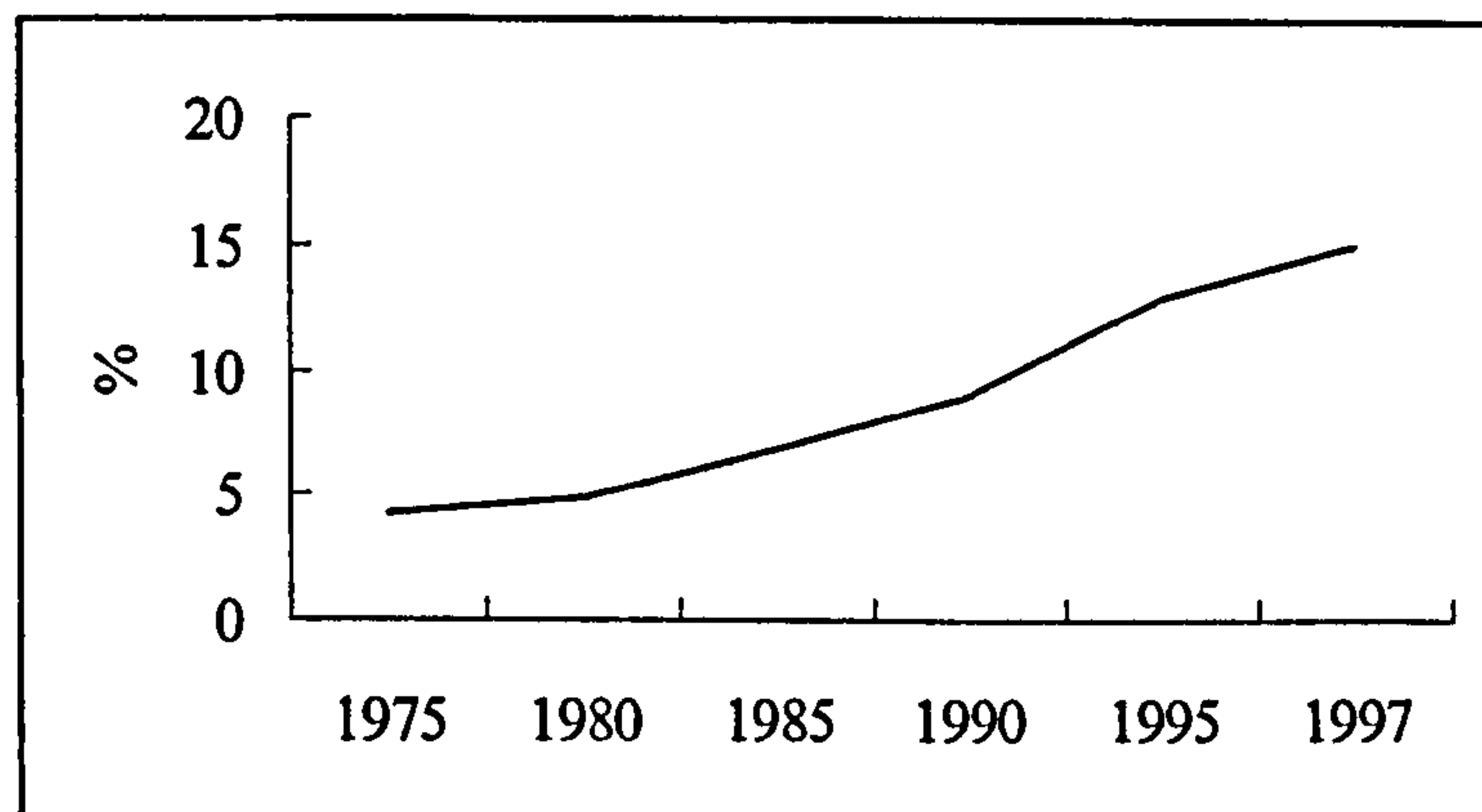
5.1.2. Changing Family Structures

Although the importance of the family and marriage is traditionally strong in Korean society, there are indications that the family system is under stress, and not only because of the move towards a 'nuclear' formation. Marital relations are vulnerable, and this is reflected in the gradual increase in divorce rates. The divorce rate, although still low by Western standards, increased from 0.5 per cent in 1975 to 2.5 per cent in 1997 (National Statistical Office, 1998). There are signs too that individual satisfaction is becoming more important (Beck, 2001). This is particularly true among those who were married by arrangement while they were young and have since been forced to maintain their marriages for the sake of their children, even though their husband-wife relationship may not have been satisfactory. The norm for young couples is now to marry for love. There is also an increasing trend for women to work outside of the house and in the public sphere. This increases their opportunities for encountering men other than their husbands. Associated with the improvement in the quality of life, there are increased expectations of an emotional life. If the marriage fails to bring satisfaction, divorce is starting to become a socially acceptable alternative (Giddens, 1992).

Growing affluence amongst the young has resulted in a rising rate of single person households as can be seen in Figure 5.2 on the following page. This has resulted in greater geographical mobility and has also contributed to a notable trend for people to

get married later in life, rather than in their twenties. In addition, demographic change, rising divorce levels, increased geographical mobility and increased female labour market participation are all tending to reduce the capacity of informal carers to provide care.

Figure 5.2. Rising Numbers of Single Person Households



Source: NSO, *Annual Report on the Vital Statistics*, Seoul, Korea, NSO, *Various Years*.

Changes in family structure (see Table 5.1.) can be explained in part by changes in such demographic variable as age at marriage, fertility, morality and migration. Social and economic conditions, such as income and housing, also affect family structure by influencing demographic trends (Park and Cho, 1995).

Table 5.1. Percentage of Nuclear Family and Directly Extended Family : 1970-1997

(Unit : %)

| Year | Nuclear | | | Directly Extended | | Other lineal family |
|------|----------------|------------------------------------------|-----------------------------------------|-----------------------|------------------------------------|---------------------|
| | Married Couple | Married Couple with Unmarried Child(ren) | Single Parent with Unmarried Child(ren) | Couple with Parent(s) | Couple with Parent(s) & Child(ren) | |
| 1970 | 5.4 | 55.5 | 10.6 | 1.4 | 17.4 | 9.7 |
| 1975 | 5.0 | 55.6 | 10.1 | 0.5 | 10.9 | 17.9 |
| 1980 | 6.5 | 57.4 | 10.1 | 0.6 | 10.6 | 14.8 |
| 1985 | 7.8 | 57.8 | 9.7 | 0.8 | 9.9 | 14.0 |
| 1990 | 9.3 | 58.0 | 8.7 | 0.9 | 9.3 | 13.8 |
| 1997 | 12.6 | 58.6 | 8.6 | 1.1 | 8.0 | 11.2 |

Source: National Statistical Office, 1998.

There has been some research into the changing nature of the Korean family due to urban-industrialisation influences (Choi, 1975). A number of problems were created by the growing migration from rural to urban areas, especially with regard to adequate housing facilities (Choi, 1975). In the labour market, a condition of industrialisation required geographical and social mobility. In response, family patterns have moved more towards the nuclear family type in the cities. The 'neolocality' of the nuclear system correspondingly freed individuals from the ties and burdens of extended families. In the meantime, patriarchal authority has declined, and the basic family good was increasingly individual happiness and freedom rather than family prosperity (Choi, 1975). Choi (1975) attempted to review the trend of the Korean family in relation to social change. She argued that the Korean family changed towards the pattern of the nuclear family system (see Table 5.2) as an outcome of urban industrialisation (Choi 1975). She also presented some evidence of the Korean family changing its form towards that of the nuclear family:

First of all, the nuclear family pattern increased whereas that of the extended family decreased. Secondly, the Korean family changed not only in its form but its content. There were some features of 'modern Korean families'. (i) youngsters preferred a modified approach to selecting marriage partners between the respective parents and the concerned parties; (ii) the young couples preferred residential separation from their parents sooner or later after their marriage (Choi 1975, p.12).

Cho (1975) notes theoretical generalisations that concern social changes affected by the industrialisation process. It is that 'industrialisation and urbanisation must necessarily disrupt large extended kinship organisations and give rise to the nuclear family isolated from the extended kin' (Cho, 1975, p.22).

Table 5.2. Composition of Households by Generation

| | (thousands, %) | | | | | | |
|------|----------------|----------------|----------------|------------------|----------------------|---------------|--------------|
| | Total | One Generation | Two Generation | Three Generation | Four more generation | Single person | Non-relative |
| 1960 | 4,371 | 7.5 | 64.0 | 26.9 | 1.6 | - | - |
| 1966 | 4,901 | 5.7 | 67.7 | 21.1 | 2.6 | - | - |
| 1970 | 5,576 | 6.8 | 70.0 | 24.1 | 1.1 | - | - |
| 1975 | 6,648 | 6.7 | 68.9 | 19.2 | 0.9 | 4.2 | - |
| 1980 | 7,969 | 8.3 | 68.5 | 16.5 | 0.5 | 4.8 | 1.5 |
| 1985 | 9,571 | 9.6 | 67.0 | 14.4 | 0.4 | 6.9 | 1.7 |
| 1990 | 11,355 | 10.7 | 66.3 | 12.2 | 0.3 | 9.0 | 1.5 |
| 1995 | 12,958 | 12.7 | 63.3 | 9.8 | 0.2 | 12.7 | 1.4 |

*Results of Population and Housing Census

Source: National Statistical Office, 1998.

Cho (1975) attempted to present the essence of the theoretical grounds for the argument:

‘(a) Industrialisation demands that occupation role be determined more by individual skill and knowledge than by ascriptive factors such as family status and sex; thus family or kinship ties no longer play an important role in job placement of family members.

The consequence of the fact that the elders can no longer control the selection of jobs of the young is that the young become freer to choose their jobs, spouses, and residence independent of the authority of the elders; (b) the opportunities for geographical and social mobility on an individual level have increased, and this separates individuals from their extended kin and further weakens the ties between extended kin; (c) individualisation also eventually creates a system of rational, universalistic, and functionally specific social relations, subversive of the opposite system of non-rational particularistic and functionally diffuse relationships which constitute the basic element of the kinship system’ (Cho 1975, p.22). On these grounds Linton and Parsons assert

that 'the extended family system is fundamentally in conflict with a modern industrial economy and value system and so it declines, and that only the nuclear family survives and remains as a functional system in industrial society' (Linton, 1949; and Parsons, 1943).

5.1.3. Changing the Cultural Value of the Korean Family

The traditional values associated with the family and family obligation have undergone change as individualism and the associated value of independence have spread through modern Korean society. As mentioned in Chapter 4, familism was an important theme in traditional Korean culture. Family was depicted as the core of the social structure and the honour of the family was crucial. Individual members were expected to sacrifice their interests to those of the family, and avoid bringing shame on the family name (Han, 1996). Such values, however, are withering away and, instead, individualism and a nuclear-family orientation is developing and growing. Thus the individual is being thought of as more important than the family, or both the individual and the family are being thought of as equally important. Such value changes tend to weaken the consciousness of family care for dependent people (Cho, 1996).

In a Confucianist patriarchal family, the family as an entity takes precedence over its individual members and the family group is inseparably identified with the clan. The most important function of family members is to maintain and preserve the household within the traditional Confucian system. Accordingly, the central familial relationship is not that between husband and wife, but rather that between parent and child, especially between father and son. Moreover, the relationships between family members are not

horizontal – that is, based on mutual love and equality – but vertical, filial piety characterised by benevolence, authority, and obedience. Authority rests with the (male) head of the household, and differences in status exist among the other family members (Park and Cho, 1995).

Rapid industrialisation and urbanisation have led to improvements in women's education and labour force participation rate, but they have not fundamentally altered the economic status of Korean women or their economic role in the family (Park and Cho 1995, p.127).

In contrast to the rapid change taking place outside the home in the Korean economy and society, within the family, traditional Confucian values and roles persisted. Nevertheless, as the family structure gradually evolved into the nuclear form centering on the husband and wife, and as more women took jobs outside the home and women's rights became a prominent issue, the family's structure began to change from the husband-dominated type to a husband-wife type. The fundamental structure of the family began to change as well, from the traditional Confucian type to a more or less cooperative type. As for the decision-making pattern within the family, there is some evidence that it is becoming more democratic and less role-differentiated as Korean society becomes more urbanised and nuclearised (Park and Cho, 1995).

The Confucian tradition of ancestral worship continues today, especially in rural areas, but the emphasis on honouring only the father's kin has weakened among the younger generation, especially in the cities. It is becoming increasingly common to honour the kin of both parents (Park and Cho, 1995). During the century, Korean exposure to Western influence, including science technology, and rationalism, has played a decisive role in the transformation of the country from an agriculture to a modern industrialised

society. Despite these changes, the Confucian influence on the Korean family is still strong, as evidenced by the persistent deference by wives to their husband's status and role, son preference, and strong kinship bonds. Whether parents and their eldest son maintain separate households or not, the relationship between parents and their children remains strong, being based on mutual reliance, and many grown children plan to live with their parents when the parents grow old and require help. The ethics and values espoused by the traditional Confucian influence of the past are changing slowly (Park and Cho, 1995).

In contemporary Korean society, as a result of the rapid transformation of the economy and society in recent decades, there appears to be a conflict between traditional values and the Confucian heritage on the one hand and Western influence through economic and social changes on the other. That conflict is being played out between parents and children, men and women, and superiors and subordinates as they attempt to apply, depending on their viewpoint, traditional Confucian values or modern egalitarian principles – in the family, in the workplace, and in their actions as individuals. This diversity is generating a great deal of tension and threatens social harmony and consensus in Korean society (Park and Cho, 1995).

In contemporary Korean society, traditional familial values and customs have significantly weakened. To demonstrate, the belief that the family has to take the main responsibility in supporting and caring for the dependent has declined. For example, successive surveys have found that in 1979 30.6 per cent of Koreans aged 14 years and over believed that the first son should take the prime responsibility, but only 19.6 per cent did so in 1996 (Ministry of Finance, 1992, 1996). The reasons for the decline

include the spread of primary, secondary and higher education, its impacts on material and occupational aspirations, and increased women's participation in employment and non-family social activities. Participation in employment among married women may be a crucial factor (Choi, 2001).

5.2. The Policy Response of the Government during the Industrialisation Period: 1962-1997

As Manning has noted (1985) social problems – which pose a potential challenge to social order - invariably accompany economic and social upheaval. This has certainly been the case in Korea. For example, industrialisation draws in workers, which leads to a sharp demand for housing in urban areas. In addition, there has been an increased incidence of mental illness (Ministry of Health and Welfare, 1997); an increase in divorce rates (National Statistical Office, 1997); an increase in alcohol and substance abuse (Ministry of Health and Welfare, 1997); an increase in crime and suicide rates (National Police Agency, 1997); an increase in the adoption of changed notions of family responsibility; resulting in there being growing numbers of elderly people without income. Social policy has a potentially important role in alleviating the impact of such problems and has in the past been part responsible for the growth of welfare states (Manning, 1985).

Although industrialisation produced a range of social problems, economic growth has enabled the Korean government to respond by promoting and expanding its social welfare measures. Korea's economic growth during the past 35 years has been one of the most rapid in the world. In line with this growth the quality of life of Korean people

has been considerably upgraded in many areas. Annual economic growth rates stood at around 9 per cent in the 1970s and 1980s, while the average annual growth rate between 1990 and 1995 was 7.2 percent. Per capita GNP rose from US\$ 82 dollars in 1960 to US\$ 10,548 dollars in 1995. The State aimed at creating a strong industrial structure based upon large Korean companies called 'chaebol' and created strong protectionist measures to preserve its domestic markets. The state facilitated the merger of chaebol by using its control of the banking system and of export-import licences. The core of Korean industry is consequently made up of around 50 conglomerate business groups each owned and run by a single family. In 1983 the combined net sales of the top 30 chaebol was responsible for 75% of Korea's output of goods and services (Koo, 1987). Indubitably, the formation of the chaebol facilitated economic development.

As Midgley amongst others has observed, social policy development cannot take place without economic development, and 'economic development is meaningless unless it is accompanied by improvements in social welfare for the population as whole' (Midgley 1995, p.23). Cutright also argued that 'a scale of national social service programs is developed and related to economic development' (Cutright 1965, p.537). There was certainly increasing demand for better public services in Korea, and the government was in a position to fund public welfare programmes if it so wished, since there was the capacity within the tax-base – at least until 1997 (Shin, 2000b).

5.2.1. Social Policies during the Export-led Industrialisation in the 1960s

In the early 1960s there was a series of legislation concerning social welfare, including

those pertaining to health insurance, disaster relief, veteran's welfare and child welfare services. Many of them, however, were the statutory consolidation of administrative orders and ordinances and many still remained inactive. Only those of instrumental value were put into effect. These included Public Assistance Programmes (1961), Pension Schemes for Military Personnel (1963) and Government Employees (1962), as well as Industrial Accident Compensation Insurance (1963). Government Employees and Military Personnel were the first two occupational groups to receive public pensions in Korea. The pension was not only a means to protect the lives of retirees, but also a means to upgrade their status vis-à-vis other occupational groups, thereby securing their continuous loyalty to the new regime which had a great shortage of legitimacy (Yoo and Kwon, 1987).

In 1963 Industrial Accident Compensation Insurance (IACI) was put into effect. It started as a state administered insurance for those employers deemed responsible for providing compensation for workers' industrial accidents. The initial coverage was limited to workplaces with 500 or more regular employees, and was gradually expanded to workplaces with 200 employees in 1970 and 16 in 1974. The Living Protection Law of 1961 was mainly a rewrite of the Chosun Poor Relief Order of 1944, which provided subsistence assistance only to those categorically poor and unable to work. It was the first statutory provision of public assistance in Korea, though a specific budget for public assistance was not allocated until 1969 (Lee, H. K., 1999).

Although a wide range of welfare-related laws were established during this period, some of them were simply underdeveloped or premature. There were a few programmes including the IACI and the occupational pension schemes for government employees

and military personnel together with pilot medical insurance programmes, which could not be referred to as social security as expenditure was inevitably very low, remaining at around one per cent of GDP. This means that the slow development of social welfare programmes in Korea since the early 1960s is attributable to the relatively low level of public expenditure on social welfare programmes. Thus, Korea witnessed the establishment of a preferential welfare system to provide special treatments only for very limited groups whose support might be crucial for the survival of the regime (Shin, 2000b).

With the restructuring of economic bureaucracy and a state-dominated alliance between the state and business, the government strongly intervened in the economy to facilitate economic development. In order to achieve EOI, the state strengthened its control over finance by the restructuring of financial institutions and actively intervening in the process of domestic as well as foreign capital. In addition, the state introduced various policy measures to support export-led growth. Korean economic development for the 1960s was a clear example of the developmental state (Shin, 2000b). Thus, during the 1960s, economic development carried on with a small degree of social welfare.

5.2.2. Social Policies during the Heavy and Chemical Industrialisation in the 1970s

The developmental experience of Korea in the 1970s, in particular since 1973 when the Heavy Chemical Industrialisation (HCI) plan was being launched, should be a model of the developmental state. The government had strongly intervened in the market to facilitate industrialisation, while making little commitment to increasing social welfare.

Preoccupied with economic development, and having close working relations with business but not labour, it deliberately paid little attention to social welfare (Shin, 2000b).

During this period two important pieces of social security legislation were introduced one was the National Pension Act (1973) and the other was the revised Medical Insurance Act (Yoo and Kwon, 1987). The former had to wait 15 years to be implemented. Its enactment typifies the authoritarian developmental state's instrumentalist approach to welfare policy. It completely bypassed interest politics (Lee, H. K., 1999).

Three years after the enactment of the 1973 National Welfare Pension Act, the Medical Insurance Act (first enacted in 1963) was revised and finally put into effect in 1977. The Medical Assistance Act was prepared to provide medical assistance to the poor who were excluded from medical insurance coverage. President Park was enthusiastic not so much about medical insurance as about national welfare pension insurance. He agreed to implement it when he was assured that medical insurance in Korea would be financed differently from the British National Health Service (Yoo and Kwon, 1987). Its compulsory coverage started with firms with 500 workers or more as a social security programme.

However, compared to the achievement of the role of the state in the economy, the developmental state in Korea played only a very small role in social welfare. The welfare system under heavy and chemical industrialisation was a residual system. For example, the national pension programme was put off for an indefinite period in spite of

the legislation of 1973. The medical insurance programme was partially introduced only for workers working in large firms. Moreover, there was a relatively low level of public expenditure on social welfare programmes. The state hardly committed to increasing its burden for social welfare (Shin 2000b). Accordingly, during the 1970s, economic development in Korea proceeded with little provision for social welfare by the government.

5.2.3. Stabilisation, Liberalisation and Social Policies: 1980-1992

The Chun Doo Hwan regime's pledge for a welfare society placed emphasis on an improvement of the medical insurance system and the revision and enforcement of social welfare service laws (Suh, 1982). And in response to the growing awareness of the ageing problem, the National Welfare Pension Act was revised to become the National Pension Act, though its implementation was handed over to the next regime, the Sixth Republic of Ro Tae Woo. Medical Insurance coverage was expanded to include persons employed in workplaces with more than 16 regular employees (1983). In addition, the definition of dependants was broadened to include members of the extended family such as parents-in-law and siblings (1984). Thereby, by 1985, 42 per cent of the population came to be covered by public medical insurance, either as general employees and their dependants or as special occupational group insurees such as government employees and private school teachers (Lee, H. Y., 1992). The self-employed, urban and rural, were still outside compulsory coverage, but they were planned to be covered by 1988. The medical insurance society-based, decentralised insurance management system was maintained despite enthusiastic reform initiatives. In

1986 the National Welfare Pension Act of 1973 was finally revised and renamed the National Pension Act and was planned to be put into effect on 1 January 1988 (Lee, H. K., 1999).

In the field of social welfare services, thousands of senior citizens' community clubs were organised with the support of the government and thousands of community day care centres were established all over the country to help low-income working mothers. For these activities, the Welfare Act for the Elderly was legislated in 1981 and revised in 1984, and the Law for the Education of Pre-school Children was enacted in 1982. The Welfare Act for the Handicapped was legislated in 1981 and revised in 1984. The Welfare Act for Children was revised in 1984 to incorporate the universal perspective of child welfare services. The Social Welfare Service Act, the basic law regarding the delivery structure, organisation, professional personnel requirements and financing of social welfare services was revised in 1983 as an adjustment to the social situation which had changed drastically over a few decades of rapid economic growth. Still, the social welfare services were understood as services for public assistance beneficiaries (Lee, C. J., 1984; Lee, C. J., 1985).

The underlying spirit of the Chun Doo Hwan regime's welfare policies was not to consolidate the state's responsibility for the people's right to welfare, but to emphasise the superiority of informal, familial, community-based mutual support groups and their co-operation with the state, particularly in the field of social welfare services. The Korean government was already aware of the new conservative trend of welfare state retrenchment in advanced Western nations. By and large, they conceded that the expansion of welfare services was unavoidable but they tried to prevent the assumed

negative effect of the welfare state which was being notified in the West (Kwon, 1998b).

During the first two years of President Roh's term, the nation was to encounter ceaseless turmoil, social unrest and the erosion of social discipline. President Roh Tae Woo, former military general, was hampered by the image that he was close to the military and not a true civilian (Morris, 1997). The Roh government's early responses to the social unrest were compensatory and welfare oriented. At the end of 1987, the Trade Union Law and Labour Dispute Adjustment Law were amended to reduce or abolish major regulations on union establishment, government control over the management of trade unions and restrictions on collective actions. When, however, further revisions were attempted by the National Assembly in early 1989 to allow the government officials labour rights, political activity on the part of trade unions and third-party intervention (as was demanded by the trade unions), the presidential veto was exercised (Morris, 1997).

In addition, the Medical Insurance System expanded its coverage to rural (1988) and the urban self-employed (1989), and the National Pension Insurance Scheme was put into effect in 1988 as planned by the previous regime. Furthermore, it was promised that the Employment Insurance System would be prepared and implemented during the period of the Seventh Five-Year Economic Development Plan (1992-1997). In addition to these major social insurance plans, the public welfare service delivery system came to be provided with professionally trained social welfare workers (1988). Many other pieces of social legislation were introduced and revised as well, such as the Equal Employment Act (1987), the Maternity Health Care Act (revised 1987), the Maternity Welfare Act (1989) and the Law for the Promotion of the Employment of the Disabled (1990) (Kihl,

1990; Park, B., 1990).

There is little doubt that the democratic transition associated with the development of civil society, in particular a growth of working-class power, greatly affected the governmental ability to develop the social security programme in Korea. However, this view fails to provide an explanation of why the Chun government did not develop social policy during the 1980s and then began to raise social policy issues in 1986. It could be argued that social policy during the first half of the 1980s was greatly affected by the requirements of economic policy, that is stabilisation measures, so that its development was significantly limited.

In order to minimise the inflationary impacts of wage growth, the state was not only trying to destroy the power of the labour forces, but also to exclude the labour from wage settlement procedures. Social security programmes were substantially subjected to the necessity of fiscal restraint so that the development of social welfare was systematically limited together with the reduction of fiscal welfare. Yet the very success of stabilisation was greatly ascribed to the sacrifice of certain social classes, notably farmers. In other words, stabilisation measures resulted in economic difficulties among farmers that the state should respond to. Regarding education and training policy, we have found that the changed role of the state in the economy characterised by the transformation from sectoral intervention to functional intervention was also reflected in the policy objectives in education and training areas.

The government increasingly focused on science and technological education and highly skilled workers' training. Therefore, it is clear that social policy was significantly

constrained by economic policy, though the content and form of social policy was affected by the extent of political power resources (Shin, 2000b).

5.2.4. Social Policies under Globalisation: 1993-1997

During the Kim Young Sam government (1993-1997), globalisation became a dominant policy idea in all state policies, which provided a significant momentum for business to retain its prevalence in society. Economic policy, which was driven under the name of globalisation policy, accelerated a transformation towards a market-based economic system by implementing a variety of deregulations and financial liberalisations. Despite these measures, the Korean government never became a minimalist one. The government continued to play the role of a participant in the market to encourage business activity and help domestic firms maintain competitiveness in the world market.

In particular, the government largely adopted a strategy of competitiveness dependant on production costs, mainly driven by lowering labour costs and deregulation. This strategy was largely affecting social policy, requiring the redesign of social policy. In March 1995 President Kim Young Sam declared 'Segyehwa' (Globalisation) of the quality of life in March 1995 (Yoon, 1996), and organised the Working Committee for National Welfare Reform to prepare a blueprint for national welfare. The Committee detailed the President's declaration on 'Segyehwa' of the quality of life, which proclaimed that the state would ultimately guarantee a minimum standard of living for every citizen. Furthermore, considering that the economic atmosphere focuses on the nation's competitiveness, the Committee proposed the paradigm shift of welfare policy

from a welfare programme to a productive and preventive welfare programme (Yeon, 1996).

The creation of a new paradigm, one which is capable of blending growth and welfare harmoniously, is required for long-term balanced development. Through measures focused on the development of human resources, welfare projects should function to stimulate the growth of the people's potential while at the same time attempting to distribute fairly the results of socio-economic development, which is an essential requirement for enhancing the quality of life. In May 1995, the National Welfare Planning Board was formed by the Segyehwa Committee. And in February 1996, this Board announced 'the Vision of the 21st Century National Welfare Reform' to enhance the quality of life. The Vision set out three specific goals as a means to achieving the main goal, which was to establish a future Korean welfare model and to provide advanced welfare services. The first specific goal was the attainment of a balance between economic integration of traditional Korean customs with the positive elements of the welfare system found in advanced countries. The last entailed the establishment of preventative and productive welfare services. Concrete strategies for achieving these goals were proposed. Firstly, by constructing a nation-wide social insurance system that should be mature. Secondly, securing a national minimum standard of living in the public assistance programme and expanding the base for a self-reliance programme that should result in the expansion of the productive welfare base. Thirdly, implementing a social welfare service that should be universal and preventive through family and community-oriented services. Finally, the participation of non-governmental organisations, firms and local community members should be emphasised (Yeon, 1996).

The Kim administration had been cautious in implementing democratic reforms as well as in expanding the social security system. The Employment Insurance Act was promulgated in 1993 and put into effect in 1995, as planned by the previous administration (Yoon, 1996). When the National Welfare Pension Law was amended in 1986, a compromise was made to merge severance allowance into the national pension gradually, and to create an unemployment insurance system. Long before the National Pension Scheme was introduced, the Severance Allowance System, predicated upon the Labour Standard Law of 1953, was functioning as a lump-sum pension for retiring elderly employees and as unemployment compensation for young workers who had been laid off. The law stipulated that employers should pay departing employees a severance allowance (one month's remuneration for one year's service). Employers insisted that to introduce the national pension insurance system, the employer's burden of financing the severance allowance should be reduced or eliminated. For the workers, as the severance allowance was already an established legal right as a deferred wage, which was the sole the responsibility of the employers, the employers' demand was not acceptable. The compromise was to merge the pension and the severance allowance and to implement unemployment insurance during the period of the Seventh Five-Year Social-Economic Development Plan (1992-1996) (Lee, H. K., 1999).

The new Employment Insurance Law of 1993 clearly emphasised its prioritised function of job training, education and placement over and above its income support function for the unemployed. It has three major elements. The first is the Employment Stabilisation Scheme to prevent unemployment, bring about a smooth employment adjustment, improve employment conditions and increase employment opportunities. The second is the Job Ability Development Scheme to encourage vocational training in the private

sector and to enable workers to develop and improve the capabilities required in their jobs throughout their working lives. The third is the Unemployment Insurance Scheme to alleviate hardships resulting from the loss of wage income through unemployment. The unemployment insurance component began with establishments having 30 or more employees, while the first and second components were applied to establishments with 70 or more employees, until their coverage expanded further in January 1998. The Korean Employment Insurance System was motivated by the necessity of an active labour market policy to help the structural adjustment effort in the labour market. The labour market was still very tight. The rate of unemployment had remained under 3.1 per cent ever since the late 1980s (Lee, H. K., 1999).

Generally speaking, the efforts of the Kim Young Sam administration in social welfare reform were focused on the systematic search for a new comprehensiveness in the changing international environment. It wanted to encourage private sector initiatives to participate in the provision of social welfare services and to expand the social security system within the general principle of small government with productivist priorities. But it had neither the comprehensive immediate action plans to strengthen the private sector, nor the notion of the balance of the responsibility between the state and the private sector. In other words, much of the concrete and specific choices of policies and programmes were left open for further discussion (Yoon, 1996).

The state's role in the provision of social welfare as a regulator was intact. The extension of the NPP to farmers and fisherman and the introduction of the EIP took place during the Kim Young Sam government. However, the government continually played the role of a regulator rather than a provider in welfare provision. In particular,

welfare reforms in the Kim government seem to be towards more limited income security programmes. They included tightening conditions of access to unemployment benefit, putting more emphasis on active measures, introducing a private pension scheme, adopting a market-conforming approach in pension and cutbacks in pensions. At the same time, the government increasingly emphasised the responsibility of the family and the role of the private sector in welfare provision.

The need for competitiveness also increasingly became the main objective of labour policy. The Kim government, in the early years, actively encouraged workers to make a concession to business with respect to wages. Labour flexibility and deregulation concerning labour protections were sought by the revision of labour related laws. The new direction in labour affairs can be said to strengthen labour flexibility and lower labour costs. Regarding the education and training system, the Kim government did make a considerable change by putting more emphasis on a vocational education system.

Consequently, it could be argued that there was a strong linkage between economic policy and social policy during the Kim government. With globalisation policy, the government increasingly became a competition state to create and/or maintain competitiveness for domestic firms and thus social policy was increasingly required to adopt the needs of competitiveness. There seems to be little doubt that one reason for this ongoing shift was the imperative of international competitiveness within the dynamics of increased economic integration. In this regard, it could be argued that social policy in the Kim government was transformed towards 'a business friendly one'.

As the policy response of the government to the social problems produced by social changes during the industrialisation period were explored, Korea implemented nearly all types of social security programmes, with the exception of family allowance. Nevertheless, some of them were simply underdeveloped or premature, so that they did not play an important role in protection against the risks and insecurities of the market. Others were designed to provide relatively small amounts of benefits, so that people had to find substantial security measures in the non-state sectors, notably the family, enterprise and commercial sectors. All these deficiencies can be ascribed not only to the small commitment made by the state to increase social welfare but also to inadequate policy design. If the role of the state in welfare provision can be divided into four types – operator of transfer, provider, financier and regulator – the government played little part in the first three. Instead, it played the role of a regulator, not only by setting the regulations which the non-state sector should observe but also by imposing greater control on the running of social security programmes.

5.3. The Basic Features of Korean Welfare System before the Economic Crisis

Since the 1960s, as noted, demand for welfare services has greatly increased because of socio-economic problems such as mass-unemployment, family disorganisation and disparities in income levels among the social classes in Korea. However, there was general hostility to western ideals of the 'welfare state' within successive Korean Governments - except paradoxically amongst employees of the state. Welfare provision for civil servants, the military and police, teachers, etc was and remains extensive and generous (Gough, 2001). This in part reflects the importance placed upon those groups

for the stability of the State. Policy makers in Korea set economic growth as the fundamental goal and have generally pursued a coherent strategy to achieve it. This has been combined with various social policies, but all entail the explicit subordination of social policy to economic policy and economic growth. This has been possible because Government officials, mainly as a result of the deference paid to them by virtue of Confucian societal values (Sakong, 1993) are relatively insulated from interest groups and have a high degree of internal coherence and loyalty. (Gough, 2001; Ham, 1997).

5.3.1. The Emergence of Public Welfare Provision

Korean governments consistently recognised the importance of 'human capital' in economic development and this is reflected in a policy emphasis upon education and health provision. This can be seen in Table 5.3. However, to put this in comparison, the Korean figures are significantly lower than the percentages of GDP spent by the UK on Education and Health in the same year (5.2 and 5.75 per cent respectively). In total, Korea only spent around 10 per cent of its GDP on welfare, in contrast to around 29 per cent of GDP in the UK (OECD, 1996). This was possible because health insurance schemes in Korea include high co-payments or user charges, so that health care finance is in effect about half-public and half-private. Furthermore Korea's housing policies were mainly based upon regulations, with little state provision and finance, although the government closely controlled the housing market. Moreover, user fees charged by public schools were typically higher in Korea compared with the West. Perhaps most important, however, the need for a public assistance programme was limited, thanks to

civil laws enforcing care for their family members upon families - which means not just spouses and children, but also siblings and parents. (Jacobs, 2000).

Table. 5.3. Aggregate public expenditures on social welfare in Korea, 1995

| | Percentage of GDP (%) |
|---------------------------------|-----------------------|
| Education | 4.94 |
| Health care | 0.47 |
| Social security & welfare | 2.15 |
| Housing & community development | 3.05 |
| Total | 10.61 |

Source: National Statistics Office, 1997.

The widespread availability of public health care in Korea suggests that most sick people had some access to health care. However, it can be seen that there remained significant inequalities. In Korea, state employees had their own distinct insurance systems that were superior to those of the general population. Moreover, the provision of a wide range of private welfare rose, and therefore the government decentralised public hospitals and placed key services under tender. For those citizens who could afford it there was the option of moving abroad for health treatment (Gough, 2001). Indeed Korea could be argued to have a form of public health insurance that could be classified as a 'National Health Service'. It is certainly the case that 'in the space of a little over a decade Korea had moved to a fully-fledged National Health Insurance system – universal and integrated, but with high co-payments and not yet geared to functioning in a re-distributive fashion' (Gough, 2001, p.172).

In addition, the local autonomous government structure, launched in 1991, drew inhabitants' attention to social welfare benefits in their region. Following affiliation to

the United Nations, international co-operation was expected to increase, and some projects, such as extension of health and medical services and welfare services were urgently required to prepare for the national unification. More systematic programmes and activities by the Government were needed to overcome the problems and satisfy the demands for health and welfare services (Ministry of Health and Welfare, 1997).

In order to meet people's expectations and desires and to establish and promote social welfare policy harmonised with income and economic levels, the Government made continuous efforts in the fields of public health and social welfare. To improve the level of national health and medical care including mental health care, the Korean government implemented policies in the following areas:

- (a) Health Promotion and Protection;
 - (b) Control of Communicable Diseases;
 - (c) Control of Mental Health;
 - (d) Medical Care System;
 - (e) Food and Pharmaceutical affairs
- (Ministry of Health and Welfare, 1997)

In addition, to improving social welfare services, the Korean Government carried out the following policies:

- (a) Public Assistance;
 - (b) Social Welfare Services for vulnerable people such as the poor, the elderly, women, the disabled and children;
 - (c) National Pension System;
 - (d) Health Insurance and Medical Aid
- (Ministry of Health and Welfare, 1997)

As shown in Table 5.4, the total expenditure for social security, that is, the expenditure for social insurance, public assistance and personal social services programmes combined, amounted to 4.5 per cent of the GNP in 1996.

Table 5.4. Trend in Social Security Expenditure by Programme: 1965-1996

| Year | Total (billion won) (%) | Social Insurance (%) | Public Assistance (%) | Welfare Service (%) | Total S.S. expend. % GDP | Central gov't SS exp % GDP | Exp./ Capita (1,000 won) |
|------|-------------------------------|----------------------------|-----------------------------|---------------------------|--------------------------------|-------------------------------------|-----------------------------------|
| 1965 | 58 (100) | 24.4 | 73.6 | 2.0 | 0.71 | - | 0.2 |
| 1970 | 261 (100) | 55.5 | 42.7 | 1.8 | 0.97 | - | 0.8 |
| 1975 | 870 (100) | 41.6 | 56.1 | 2.3 | 0.89 | - | 2.5 |
| 1980 | 6,107 (100) | 65.9 | 32.0 | 2.1 | 1.67 | 0.5 | 16.0 |
| 1985 | 16,766 (100) | 76.2 | 21.1 | 2.7 | 2.32 | 0.5 | 40.8 |
| 1986 | 19,461 (100) | 75.6 | 19.7 | 4.8 | 2.15 | - | 47.3 |
| 1987 | 23,181 (100) | 74.6 | 20.7 | 4.8 | 2.19 | - | 55.8 |
| 1988 | 30,594 (100) | 75.2 | 21.2 | 3.6 | 2.43 | - | 72.9 |
| 1989 | 40,036 (100) | 75.3 | 20.4 | 4.3 | 2.83 | - | 94.5 |
| 1990 | 53,919 (100) | 74.3 | 19.4 | 6.3 | 3.15 | 0.8 | 125.8 |
| 1991 | 70,846 (100) | 68.5 | 19.2 | 5.7 | 3.43 | 0.9 | 163.8 |
| 1992 | 80,484 (100) | 77.8 | 16.9 | 6.0 | 3.50 | 1.0 | 184.3 |
| 1993 | 105,717 (100) | 81.4 | 10.4 | 4.6 | 3.98 | 0.9 | 201.1 |
| 1994 | 116,779 (100) | 85.1 | 10.8 | 4.1 | 3.48 | 0.9 | 239.2 |
| 1995 | 137,008 (100) | 85.6 | 10.0 | 4.6 | 3.93 | 0.8 | 303.8 |
| 1996 | 172,879 (100) | 85.9 | 9.2 | 4.9 | 4.47 | 0.9 | 379.5 |

Source: *Government Budgets*, the Ministry of Economic Planning Board, each year; *White Paper of Health and Welfare*, Ministry of Health and Welfare, each year.

This presents a considerable growth from 0.7 per cent in 1965 and 2.2 per cent in 1987. The amount of social insurance expenditure increased rapidly and steadily from 24 per cent in 1965 to 86 per cent in 1996, whereas that for public assistance expenditure decreased drastically from 74 per cent in 1965 to 9 per cent in 1996. Expenditures on social welfare services fluctuated between 1.8 per cent in 1970 and 6.3 per cent in 1990.

However, as Table 5.5 demonstrates, compared to other OECD countries public spending on social protection, including pensions, is extremely low in Korea. The exception to this is pensions for the military and other public sector employees. The rest of the population is largely reliant upon the national pensions system. The National Pension Scheme did not start until 1988, but it has since been extending its coverage and building up its fund over a 20-year period. As Gough points out full pensions will not really start to fall into place until 2008 (Gough, 2001).

Table 5.5. Social Security Expenditures in Selected Countries

| | Korea | United Kingdom | United States | Germany | Sweden |
|---------------------------------------------------------------------|-------|----------------|---------------|---------|--------|
| Total Social Security Expenditure as Percentage of GDP ^a | 5.28 | 23.64 | 15.66 | 30.05 | 38.33 |
| Mandatory Private Social Benefits as Percentage of GDP ^b | 1.40 | 0.23 | 0.47 | 1.39 | 0.62 |
| Private Share (b/a) (%) | 26.5 | 1.0 | 3.0 | 4.6 | 1.6 |

Source: Shin, 2000b.

Note: Korea figures are for 1996; other countries for 1993.

- a) Including public social expenditure and mandatory private social benefits. Voluntary private social benefits are not included.
- b) Mandatory private social benefits are defined as those benefits which economic agents (often employer) are legally obliged to provide, or benefits derived from private insurance arrangements which economic agents are forced to take up.

5.3.2. Social Policy under the Economic Growth Strategy

In Korea, political debates around welfare policy development illustrate tensions between welfare expansion and economic growth. Indeed, the Park regime in the early 1960s already recognised the legitimacy of citizen's basic social rights and the state's obligation to protect them. Park's broad-based welfare programmes could not be implemented due to economic concerns.

Korean governments considered economic development as their top policy priority, and assumed only a limited role in social welfare since the beginning of the country's rapid industrialisation. In particular, social welfare policies between the 1960s and the 1970s were considered secondary to economic policy and were developed only to the extent that they would not hinder economic development. Such policies as these mainly dealt with problems associated with industrial accidents caused by the process of industrialisation. For example, the Industrial Injury Compensation Act (1963) and the Medical Insurance Act (1962) were enacted during the 1960s. However, legislation was enacted in the 1970s to reduce social inequality caused by economic development and to improve the welfare of the Korean people, for example the National Welfare Pension Act (1973). During this period, much social welfare was focused on pension and health care schemes for employees in industrial firms and government or private school employees. It was not until the beginning of the 1980s that social welfare was adopted by the Korean government as a national goal as a means to achieve a democratic welfare society.

Shin (2000b) has argued that economic and social policies have not been determined in isolation from each other. He also has pointed out that the form and content of social policy has been greatly constrained by the requirements of economic policy.

Since the early 1960s the Korean government chose the strategy of minimising labour costs for competitiveness in the world trade markets, which has subsequently had an important effect on shaping social policy. Social policy in Korea has been embedded in and constrained by the requirements of economic policy. Yet, the nature of policy linkages between economic and social policies varies according to the area of social policy and the content of economic policy (Shin 2000b, p.i)

As Kwon (1999b) points out during the period 1961-87 the governments of Korea pursued a strategy that can be summarised as legitimisation through economic performance. For instance President Park's government pursued an 'economic growth strategy' whereas President Chun aimed at 'economic stabilisation'. Consequently, economic policy took precedence over all other policy considerations, including social policy.

5.3.3. Social Welfare under The government's rationale for fostering Confucianism

This chapter has outlined the implications of the radical and exceptionally rapid changes in the demography, economy and social formations of Korea, over the last few decades, for the care and support of its dependant people. The creation of an industrial society, the concentration of the urban population, the urgent and massive social problems arising from phenomenally rapid urbanisation, the undermining of more traditional family and community systems of social support and control: the problem of welfare became societal rather than a family problem.

Nevertheless the development of social policy continued to be facilitated by Confucian values. In Korean society, citizens were under strong moral and, sometimes, political pressure to sacrifice their individual interests for unconditional family unity, to keep familial problems within the family and to abstain from resorting to social or governmental measures in an effort to meet familial needs (Kim, 1990; Chung, 1991).

Since the 1960s, Korea has shifted from being mainly an agrarian, rural society to an urbanised and industrial, newly modernising one. Of all the Asian modernised or modernising societies that have Confucian ethical heritages, it appears that Korea is one of the most closely bound to the relational aspects of this heritage. As mentioned, demographic changes, urbanisation and industrialisation have contributed to changes in Korean family structure. Traditionally, the Confucian ethical and relational system holds the eldest son responsible for the care of his family and elderly parents, although in modern Korea it is possible for another son to assume this care-giving role. The second cardinal virtue of Confucianism requires the obedience of the son to the father and the third requires the obedience of the wife to the husband. The political structure's emphasis on economic development makes it difficult to moderate any social stress factors through the development of a countervailing social welfare infrastructure. There was indeed a deliberate governmental strategy not to develop a supporting social infrastructure or a modern welfare state package of social services and income policy programmes such as might assist the elderly and their informal caregivers.

The government's rationale for fostering 'Confucianism' and family responsibility appeared to be disingenuous. At times, Korea's political leaders appeared to be convinced by their own rhetoric that supportive income and social services would undermine the Confucian tradition of family care for dependant people. The political-economic drive for low income taxes and low taxes on equity transactions, combined with subsidies and incentives to encourage exports plus a substantial commitment to the military budget, left few resources available for social services. The government thus used the Confucian ethic as 'a rationale for its laissez-faire approach to the problems posed by dependant people' (Palley 1992, p.801).

While several themes have dominated attempts to account for the economic success of these societies - notably their distinctive 'developmental states' and their heavy emphasis on education- the most wide-ranging and popularly current explanation has been based on culture. As White and Goodman point out:

Most cultural explanations have in turn been based on some notion of Confucianism which is held to be a key part of the shared heritage of East Asia as a whole. In an earlier era (the 1950s and the 1960s), Western observers largely perceived Confucianism as a heavy constraint on the economic programme because of its stress on the importance of preserving tradition, its reinforcement of a social structure which, despised and restricted commercial and industrial pursuits, and its hostility to technological innovation and entrepreneurship. Since the 1970s, however, Confucianism - in a protean variety of versions - has been rediscovered as a positive historical force (White and Goodman 1998, p.18).

Confucianism was certainly commonly cited as having provided the fundamental cultural underpinnings for the East Asian economic success. This is seen to be an important element in the State's emphasis on education, strong family relations, benevolent paternalism, social harmony and discipline, respect for tradition and a strong work ethic (White and Goodman, 1998).

Many right wing theorists and politicians concluded that the nuclear family was the main cause of many social problems, in particular, widespread poverty and psychological difficulties among the elderly and children. It is argued that the nuclear family, did not properly maintain Confucian virtues such as family solidarity, filial piety and self-sacrifice. As a consequence it is seen as disrupting the harmonious and stable support among family members. This ideological critique was 'nurtured by an

inadvertent application of the functionalist thesis of family nucleation to Korean society' (Chang 1997, p.23).

As Chang (1997) pointed out, the Korean experience of averting political demands for 'progressive' family welfare by moral criticism of the individualist nuclear family, was both similar to and different from the Western experience. Furthermore as Chang argued, 'by comparison with the Western New Right's use of the moral politics of the family for legitimating major cutbacks in welfare programmes (or in 'rolling back the state'), the moralisation of family issues in Korea has had a preventive effect on the starting up of any such progressive welfare programmes. In other words, the historical contexts in which family politics operate are different. Moreover, the moral politics of the family in Korea has involved fewer institutional links with congressional and governmental activities than in the West. Social debates and media coverage of family issues from a Confucian/liberal perspective have often encouraged non-action on the part of the state so that a sort of de-politicisation of family issues has been induced. It is in this social and cultural environment of strong public conservatism that *de facto* political manipulation becomes highly effective in suppressing political demand for progressive state support and intervention' (Chang 1997, pp.37-38).

Nevertheless there remained a further similarity between Korea and the West. The moral politics of the family in Korea was effective in legitimating the absence and deficiency of public protection programmes for needy families and individuals, but not in alleviating family problems via the revitalisation of traditional family structures or attitudes. Somerville describes a similar failure of the New Right in western countries as being a result of 'the sheer weight and momentum of major demographic, economic,

social and cultural shifts in the sub-stratum of advanced industrialised societies in the twentieth century' (Somerville 1992, p.119). However, even if we suspect that many liberal politicians in both Korea and the West do not necessarily have a genuine spiritual commitment to the moral rehabilitation of the family *per se*, they may still experience political success. This is because 'the moral discourse on the family does appear to have been useful in legitimating their suppression of welfare programmes' in the first place (Chang 1997, p.38).

Such moral discourse also, of course, impacts upon the role of women in Korean society. Kim, H. J. (1996) argues that Confucianism represented a subordination of women. In Korea a woman should be a faithful wife, a devoted daughter in law, a self-sacrificing mother within the home and denied a role in public life. In Korean tradition, when women are married, it is more important for women to take care of their parents in law than their own parents. In Korea nearly 54 per cent of elderly people live with or very near to their grown up children (Kwon, H. 2001). 'Sons provide emotional and financial support and resources from outside the family, but they are unlikely to help with instrumental, hands on services' (Sung 1990, p.615). Filial piety may be a continuous burden to the majority of women, who end up caring for parents and parents in law, in the absence of a policy that addresses the needs of the total population and places an undue burden on women (Choi, E., 1994). Inequalities between men and women exist in the workplace as well as in the home, they tend to be in lower positions when their employers emphasise Confucian values within the workplace, as within the vast majority of the '*chaebol*'.

There was strong criticism, particularly from feminists, that the Korean governments promoted Confucian values to facilitate governance of its people rather than from any ideological imperative. However, there were indications that the strength of Confucian values within policy-making began to change. Women were increasingly active in the public sphere and recognition of this was achieved with a reformed childcare policy in 1997 and the slow improvement in women's rights over the last decade – though this has not been without resistance from traditionalists.

5.4. Summary

This chapter has examined the implications of the radical and exceptionally rapid changes in the demography, economy and social formations of Korea since the 1960s. The industrial and economic base of Korea grew dramatically until the late 1990s. This facilitated the development of social policies – particularly in areas such as education, health and housing, which support economic growth. However, although the structure of the family changed to be closer to its structure in the West, it could be argued that evidence pointing to a broader 'Westernisation' of Korean society was premature. Confucianism may have been a factor in Korea's development, but it may yet prove a hindrance to any further moves to modernity and equalisation of life chances amongst its citizens.

Prior to the economic crisis of 1997 Korea tended to rely on Confucian ideology as an apology for limited government action in social welfare provision. The Korean government strongly urged its people to provide social support to their family members.

Culture thus served as a justification for the lack of a comprehensive social welfare system in Korea. Given rapid economic growth and this cultural belief, Korea was not under pressure from powerful constituencies to provide comprehensive social welfare provision.

In the following chapter the development of social policy in Korea after the economic crisis will be discussed in terms of both cultural and structural influences. The next chapter will elaborate these themes in relation to the history of Confucianism as a rationality of governance. How does the Korean welfare regime respond to social problems in the aftermath of economic crisis?

Chapter 6. Social Policy Responses under the Confucian Governance II: the Economic Crisis and its Impact 1998-Present

Since the beginning of the first Five-Year Economic Development Plan in 1962, Korea has made major economic achievements. Policies intended to encourage growth have led to a substantial increase in the GNP per capita; Korea has now moved to the upper developing countries group in the United Nations ranking. A remarkable reduction in population growth and dramatic education development have together played a key role in economic development. Outstanding progress was made in raising the standard of living; average household income levels rose significantly and the unemployment rate remained at a low level. Poverty and social difficulties were considered to have been solved due to economic growth and full employment while the informal, private and familial welfare system compensated for the lack of public welfare.

The 1997 economic crisis, however, clearly revealed the limit of these policies. Rising unemployment and the decrease in nominal wages have destabilised households severely, and the poverty level has risen both in absolute and relative terms while income disparities are widening. While there has traditionally been a gap between urban and rural areas in terms of wealth, new patterns of poverty have emerged in the cities. The crisis has brought a realisation that economic development cannot be socially sustainable without social policy measures. As a result of this, the government has introduced a set of temporary measures as well as an important reform of the welfare system. In this respect, this chapter intends to explore the impact of the crisis and then identifies the government's response to the crisis.

The thrust of this chapter is on the policy responses to perceived social problems in the aftermath of the economic crisis. Also, the relationship between the economic situation in the aftermath of the economic crisis of 1997 along with social policy making will be examined in this chapter.

This chapter is divided into five sections including the introduction and summary, the next section examines the impact of the economic crisis, which produced growing demands for social welfare. Section three tries to explore the development of social policy in the aftermath of the economic crisis of 1997 in order to clarify the policy direction which has primarily influenced mental health policy making. Section four identifies the basic features of the policies informed and shaped by Korean politics and culture after the economic crisis of 1997.

6.1. The Impact of the Economic Crisis and Growing Social Demands for Welfare

The Korean welfare regime quickly became overwhelmed by the economic crisis which hit much of Asia in 1997. The growth in welfare over the previous thirty years had largely relied upon the expansion of employment within the orbit of strong families, plus growing co-payment for services. Certainly, the reliance on overseas aid was diminishing in the late 1990s but many of the social sectors were open to foreign commercial penetration (Gough 2001, p.181). Gough summarises the main social effects of the crisis as follows: 'a collapse in currency values, which generated higher import prices and extensive internal price changes, including falling asset values; a

drastic fall in output and thus in demand for labour; falling state revenues and a squeeze on public spending; fears of the erosion of the social fabric' (Gough 2001, pp.181-2).

6.1.1. The Social Impact of the Crisis

The social impact of the crisis was analysed by Manuelyan Atinc and Walton (1998) and Manuelyan Antic (2000). They pointed out that the rates and depth of poverty increased markedly. Following the crisis, there was a declining demand for labour and the resultant loss of wages in the population brought about a collapse in private consumption. Interestingly, they noted that rates of inequality did not increase significantly, though this was in part due to the collapse in the financial assets of the rich and middle classes. Their work points to the ways in which many poor households were forced to cut back on nutrition, postpone health care and make other family adjustments such as removing a child from education. However, the crisis turned around more quickly than most commentators expected, with economic recovery beginning as early as 1999. (Shin, 2000a). Gough portrays the situation as follows:

In Korea, meanwhile, labour demand fell sharply and, though real wages fell, the major impact was on unemployment, especially among women. As a developed industrial economy, Korean households had fewer rural resources to fall back on. At this time, Korea was already embarked on a restructuring of trade, economic and social policy, under pressure from the US to liberalise its economic structure. The first wave of reforms, introduced by the Rho Tae-woo government in 1988, included Medical Insurance, the National Pension Programme, the Minimum Wage and new labour laws. Following the financial crisis, a second wave of reforms followed in 1998-1999, coinciding with the election of Kim Dae Jung as president. The economy was significantly liberalised and the close links between the state and the '*chaebol*' were loosened. This was coupled with moves towards a more western style of welfare

system. Expenditure on unemployment insurance, wage subsidies and public works programmes escalated, to an unprecedented 4 percent of GDP in 1999. In addition, the National Health System was restructured and expanded, pension entitlements were liberalised and an expanded Labour Standard Law introduced. A 'Labour-Management-Government' Committee was established which moved away, at least in name, from state-business symbiosis to a tripartite – state-business-labour – form of corporatism. In short, greater exposure to the global economy and the subsequent crisis has served to undermine the influence and the social provisions of the chaebol and required the state to develop a more autonomous western-style of social policy.

(Gough 2001, pp.182-3)

6.1.2. Mass Unemployment

The economic crisis of 1997 had a considerable impact on the common people in Korea. The crisis resulted in one out of five households having someone unemployed, suicide rates rose by 50%, and homeless people slept outside the subway stations (Park, T. W., 1999). Statistics show that the number of poor people living below the poverty line rose to 7.8% in 1998 (MoHW, 1999). Park, T. W. (1999) portrays this situation:

Men who were the primary breadwinners for their families left home in shame and embarrassment after they were laid off. They did not get much assistance from the state. Services for homeless people were underdeveloped in Korea. Social tensions rose to a dangerous level. Social security benefits for unemployed people were considered inadequate (Park, T. W. 1999, p.133).

This was a system dependant upon a strong family network and which, over the past three decades, collapsed as bread winners could not find work (Yoo, G., 1998). As a consequence, urgent relief for suffering people was much needed (Tang, 2000a).

Despite IMF rescue packages, the financial crisis was not showing any signs of receding. Instead, soaring unemployment and sharply devalued currencies led to the further deterioration of an already weakened economy (Lee, H. K., 1999). The unemployment rate rose to 7.6 per cent in July 1998 from less than 3.0 per cent before 1997, due to the massive layoff scheduled by the restructuring public sector and big business corporations (Lee, H. K., 1999). Lee, H. K. (1999) explains the situation regarding unemployment:

These official statistics on unemployment did not include the unemployment of daily workers, whose numbers add up to some 1.9 million. More than 1.5 million unemployment officially counted plus about 0.4 million unemployment daily workers makes about 2 million unemployed already. The rise in the number of the homeless was a relatively new but prominent social problem in most of the large cities. A good deal of survey research on the situation of the unemployed and the homeless was needed to develop appropriate programmes for them (p.35).

The economic decline, corporate crisis and a credit squeeze caused lay-offs, real wage declines, weak demand for new labour market entrants and falling margins in the informal sector. Unemployment in Korea reached 7.6 per cent in July 1998 (1.5 million) and the increases in unemployment in turn required increased outlays of unemployment benefits by the Government under the EIS, just when public revenues were declining. Most of the unemployed are expected to be people not covered by the EIS, and it will be important to find ways to shelter these individuals from the worst of the crisis. In addition, the crisis will have a significant impact on the elderly who are unable to rely on relatives and friends for support, since the NPS is not due to begin disbursement until the year 2008.

The economic crisis affected the poor by reducing income, and by increasing prices, unemployment and underemployment. Unemployment rose from 3 per cent before the crisis (7.6 per cent in July 1998) to about 8 per in 1999. As the number of poor increased, it placed pressure on the government, at a minimum, to improve the current fractional coverage of the Livelihood Protection and Medical Aid programmes. Between October and December 1997, the Korean won depreciated by over 50 per cent, increasing the relative price of medical care. This price increase occurred at a time when Koreans, and especially the poor and unemployed, were least able to afford the high out-of-pocket costs of health care.

6.1.3. The Impact of the Economic Crisis on Family

After the economic crisis unemployment in Korea may have a greater social impact than the number represents. Korean society was unaccustomed to high unemployment because of its rapid economic growth and the corporate culture of lifetime employment. Consequently, institutional capability, such as a social safety net to deal with unemployment, is rather poor. Furthermore, married women are not active in the labour market and households are usually dependent on the labour income of their (male) heads. Unemployment of the male head of the family means not only financial disaster for the family, but also a social stigma and mental burden to the male head himself.

The male unemployment rate went up to six per cent in all age group between 35 and 59. Considering that a great number of people among them were the main breadwinners in households, social stress was much higher than the figure suggests. For example, the

crime rate increased by 11 per cent in 1998 compared to 6.3 per cent in 1997 and the increase in divorce was up by 25 per cent in 1998 compared to 0.9 per cent in the previous year.

The most widely investigated problems among the unemployed in their family are material deprivation and family disruption due to one member's unemployment (Lee, E., 2000). After the economic crisis both unemployed and employed experienced severe reductions in income, resulting in reduced consumption of food (70 per cent among the lower class), clothes and shoes (30 per cent), entertainment (29.4 per cent), furniture and home appliances (28.6 per cent), and eating out (28 per cent) (National Statistical Office, 1999). Lower-class unemployed people suffer more from income loss and income reductions because most of them are excluded from various social benefits such as unemployment insurance, pensions, and retirement benefits. According to the National Survey on Income (1999) in Korea, income gaps categorised by levels of educational attainment were exacerbated after the end of 1997, with 16.7 per cent of income reductions and 15 per cent of reductions in household spending for middle school graduates, and 14.2 per cent and 20.4 per cent for some university graduates.

The National Statistical Office reported that the bottom 20 per cent lost 20 per cent of their income and reduced 15 per cent of their household spending, while the top 20 per cent gained more income by 27 per cent in 1999. This result shows that economic difficulties are not evenly distributed across social class, and lower class people suffer more from economic deprivation while the rich gain more profit from higher interest rate changes as a result of the economic adjustment programme right after the IMF intervention. This social disparity is associated with a high level of suicide and crime

rates, loss of self-efficacy and control, and a high level of alcohol consumption and drug abuse.

Furthermore, social and economic crises in Korea affected marital conflicts and weakened family relationships, showing a high increase in divorce cases from 22,324 couples in the first quarter of 1997 to 36,735 couples in the same period of 1998, or a 64 per cent of increase (National Statistical Office, 1999). Family disruption such as divorce and frequent marital conflicts between a couple would influence higher cases of runaway youth and nutritional deficiency among children as well as loss of close social relationships, which are detrimental to the physical and mental health of the unemployed.

6.1.4. Growing Social Demands for Social Welfare

It is also worth noting that there was a sweeping change in the public perception of the role of the state in social welfare over this period. According to the survey research conducted twice, in May 1997 and in October 1998 (see Table 6.1), 83 per cent of the respondents replied that the state was responsible for citizens' social welfare in 1998, whereas 49 per cent responded in that way in 1997 (Shin 1997; 1998).

The figure suggests that social demands for social rights have been largely acknowledged among the public in Korea since the economic crisis of 1997 bringing about growing demands for social welfare. In particular, the structure of income distribution got worse after the crisis. According to the data from the World Bank

(Show, 1999), the number of people living in poverty in urban sectors increased from 8.6 per cent in 1997 to 19.20 per cent in 1999. This increase clearly indicates that the crisis has engendered large reallocations of people and sharp declines in middle-class standards of living.

Table 6.1. The people's attitude over the state's responsibility for individual welfare %

| | May 1997 | October 1998 |
|------------------------|----------|--------------|
| Individual responsible | 51 | 17 |
| State responsible | 49 | 83 |

Note: These figure were obtained from the following question: please choose one statement that comes closest to your view: Individuals should be responsible for their own welfare; The state should be responsible for everyone's economic security.

Sources: Shin and Rose, 1997 and 1998.

In this situation, policy initiatives that go against the perceptions of a large number of citizen voters might well prove unfeasible. Thus, the government in Korea has to be sensitive to the changed public perceptions. Social security policy has emerged as a crucial measure to respond to them, not least the establishment of a social safety net. Along with the growing social demands for social welfare, the Korean government had to respond to the problem of mental health particularly as a social rather than family problem in terms of social protection.

6.2. The Policy Response of the Government after the Crisis

In the aftermath of the economic crisis Korean social policy has continued to be adapted to the economic market system. The government has attempted to pursue a strategy of

moderate development in welfare provision, in which the average level of provision, measured either by per capita social expenditure or its ratio to GDP, would be prevented from going to either of the two extremes, remaining instead on roughly the existing level. It is an important part of the government's social policy agenda to adjust the structure of welfare provision.

6.2.1. Expansion of Unemployment Insurance

The unemployment insurance programme has also been greatly expanded and reformed. Unemployment insurance was launched in 1955 to cover only full-time workers and companies with 30 employees or more. After the crisis, it was expanded to include workers at all workplaces in October 1998. In order to better support the unemployed, the government introduced new programmes and increased the budget for unemployment. As a result of this, the benefit period has been extended and the amount of aid available increased. Spending on active labour market policies also increased from 0.2 per cent of GDP in 1997 to 2.4 per cent in 1999 (Ministry of Health and Welfare, 2000). Within the Employment Insurance Service, the government has provided subsidies to firms that employ workers who had been laid off (the subsidy period has been lengthened to eight months and firms are allowed to collect more than one subsidy at a time). Various wage subsidies have also been introduced to encourage firms to retain workers (4200 companies received such support in 1998). The share of the expenses went to public works projects and to loans for the unemployed. For such loans, applicants are required to find co-signers, thus ensuring that only the relatively better off unemployed have a chance of getting a loan. Concerning public works, in

1998, the number of applicants for these programmes was 400,000, of which 100,000 were at a central level and 340,000 at a local level (Ministry of Health and Welfare, 2000). Public works programmes were conceived as an income support for the applicants. The eligibility criteria are mainly based on income, skill, age (30-55), and family dependence. Practically, public works have been useful for the public sector as they mainly apply to university graduates who have helped to improve the computerisation of government records.

Measures have also been taken to expand the Public Employment Service and improve its efficiency. A one-stop service system was created in August 1998 integrating vocational training, employment insurance and other services. The number of offices was tripled from 52 to 142 in 1999 (Ministry of Health and Welfare, 2000). They are concentrated in the seven largest cities where four fifths of the unemployed reside. However, the number of staff working in these offices remains low compared to the number of persons registered, which has increased eightfold. As a result of the reform, the number of people who have received benefits rose to 300,000 in 2000, up from 50,000 in 1997. The total amount of payments also rose to 470 billion won (235 million GBP) in 2000, up from 79 billion won (39.5 million GBP) in 1997 (Ministry of Health and Welfare, 2001).

6.2.2. The Employment Insurance System (EIS) and Work Injury Insurance (WII)

In the aftermath of the economic crisis, declining macroeconomic conditions brought about major disruptions in the labour market. Soaring unemployment caused

disproportionate suffering among non-regular and low-educated workers. Remaining jobs became unstable and the hard-core disadvantaged group in the Korean labour market experienced recurrent unemployment. Wage differentials between low-end workers and others widened while income distribution was aggravated (Lee, W. et. al., 2001).

Paradoxically, non-regular workers and employees in small business were restricted or excluded from social insurance coverage. In other words, the existing welfare system, including the WII and EIS, turned out to be insufficient to cover all types of workers (Lee, W. et. al., 2001). Moreover, before the crisis, only those workers belonging to firms with more than 30 employees were covered by the EIS (Ministry of Health and Welfare, 2001).

In the light of such shortcomings, the Korean welfare system, including the social insurance system, is in need of some major revisions so that all types of workers are appropriately protected from the potential hazards of work-related injury or unemployment, and hence are ensure more economic stability throughout their lifetimes (Lee, W. et. al., 2001).

The coverage was extended in March 1998 to workers of firms with at least five employees and, in October 1998, to firms with less than five employees, and to temporary and part-time workers employed for at least one month and working more than 18 hours a week. Despite these major improvements, much remains to be done to upgrade the system to be closer to the OECD standard. First, the number of workers covered by the EIS is still insufficient: only 12.8 million out of the 20 million Koreans

employed in July 1999 (OECD, 2000). The categories of workers who are still not eligible include part-time workers. Part-time workers who have worked more than 18 hours a week and 80 hours a month are eligible, along with civil servants, the self-employed and unpaid family workers. Second, the number of those who actually receive benefits is low (only 12 per cent of the unemployed) (OECD, 2000). This is mainly the case for workers of small enterprises whose employers have not paid their contribution. Apart from the strict eligibility criteria previously mentioned, there are a great number of potential beneficiaries who are not informed of its existence, even though significant efforts were made to raise public awareness through large-scale and continuous advertising campaigns (television, subway posters) after the currency crisis. Third, unemployment benefits are equal to only 50 per cent of the workers previous salary. This can, to a certain extent, be considered as an incentive for the beneficiaries to find a new job. Finally, the duration is still too short. The most important challenge for the government is now to increase greatly the coverage of the EIS. Local government can play a role by helping to identify the characteristics of the excluded unemployed and by improving circulation of information about the programme.

Previous to July 2000, the Work Injury Insurance Programme required companies to employ five or more workers for an employee to become eligible for insurance coverage. To aid the victims of industrial accidents and their families, coverage for industrial accident compensation insurance was expanded in July of 2000 to include self-employed workers. Recognising that those employed in the workforce are not the only ones in need of assistance, services for the elderly, the disabled, and children have also been improved and expanded under new governmental programmes and policies (Korean Information Service, 2001).

In the recent evolution of Korean social safety nets, coverage extension of the EIS has a special meaning in that it stimulated coverage extension of other social insurance programmes. In July 2000, following the initiative of the EIS, WII and the Wage Claim Guarantee Fund extended their coverage to workers of small firms with less than 5 employees. National Health Insurance extended its coverage in July 2001, prior to which it covered those workers in firms with less than 5 employees only in the capacity of self-employed, not as employees (Lee, W. et. al., 2001).

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Although the EIS and WII programmes do not themselves enhance job security or work safety, they do help workers to become more actively involved in the production process, thus enhancing their productivity. Consequently, as measures of the productive welfare system, the EIS and WII enhance welfare and productivity by protecting workers from various risks such as illness, work injury, disability, unemployment, and retirement without deterioration of work incentives (Lee, W., Hur, J., and Kim, H. 2001).

6.2.3. Increasing Temporary Public Works Programmes and Expansion of Basic Livelihood Protection

The TLP was created after the 1997 economic crisis with the aim of helping newly unemployed people whose income was less than 230,000 Wons (one-sixth of the average factory workers wage) (Ministry of Health and Welfare, 2000). After 1982, the number of recipients of livelihood programme assistance was gradually declining, but it has started to recover slightly since 1997 with the introduction of the TLP. In 1999, the

total number amounted to 1.9 million people, or 4.4 per cent of the population, but only half of those are estimated to be living below the poverty line (Ministry of Health and Welfare, 2000).

As the nation struggled through the financial crisis of 1997-8, the government firmly held to its welfare goals and formulated policies to expand the social safety net. One policy that supports the framework for productive welfare is the Basic Livelihood Protection system. To deal with poverty in a more fundamental way, the government introduced the system in October 2000 (Korean Information Service, 2001).

Significant changes have recently been introduced with the enactment of the National Basic Livelihood Security Law in August 2000 which went into effect in October 2000. With this law, social assistance will become a right of all those who meet the eligibility requirements. Furthermore, the level of Livelihood protection, which has been gradually raised to near the minimum cost of living (60 to 90 per cent in 1997), has reached the 100 per cent level (Ministry of Health and Welfare, 2001). At the same time, in compliance with the principles of productive welfare, beneficiaries of social assistance who are able to work will be obliged to search for jobs and to accept training, public works jobs and any job placements provided by the local welfare office (Korean Information Service, 2001).

6.2.4. National Pension System

Further steps to expand social welfare have also been taken. The National Pension System was first introduced in 1988 to include all offices and workplaces with 10 or more employees. In April 1999, it was expanded to cover the entire working population. The number of insured persons under this plan stood at 7.84 million in 1997. In more recent years, a total of 16.68 million workers at all levels of society subscribe to the pension plan, individually or collectively, through their employers. As of January 2001, the number of pensioners stood at 620,000. The government has also introduced a pension plan for elderly people who reside in rural areas. Citizens in this age bracket and rural locals qualify to receive a pension after paying into the system for a minimum of five years (Korean Information Service, 2001).

6.2.5. Introduction of Means-tested Non-contributory Assistance to the Elderly Poor

To help stabilise the livelihood of low-income elderly persons, the government significantly expanded the target population of those receiving subsistence grants to 715,000 in July 1998, up from 265,000 before the programme was initiated. As part of the programme to improve health and medical services for the aged, the number of nursing homes for the elderly and treatment centres for those with senile dementia rose to 121 in 2000, compared to only 63 in 1997. By 2000, the number of centres despatching nurses for home treatment had increased to 76, up from 46 in 1997 (Korean Information Service, 2001).

The Old Age Allowance is provided under the Livelihood Programme for the elderly poor who are not covered by the public pension scheme. The number of recipients was 660, 000 in 1999 and reached 715,000 in 2000 (Ministry of Health and Welfare, 2000). There are public programmes to enhance employment opportunities and health for the elderly. As the support of family members of the elderly is weakening, institutional care has been developed, including welfare facilities such as elderly homes and nursing homes. In particular, social community care services for the elderly have been extended with currently 78 home help services, 42 day care centres and 21 short-term centres. Central and regional governments support the leisure facilities. (Ministry of Health and Welfare, 2000)

The National Pension Scheme does not cover the totality of the population, as qualification for a pension requires a minimum of ten years of contribution. However, people who fulfil specific conditions may qualify for a pension with only 5 years contribution. Other occupational pension schemes established for civil servants (1960), military personnel (1963) and private schoolteachers (1975) cover 200,000 persons, i.e. 6 per cent of the labour force. The coverage was limited to workers of firms with 5 or more employees. Special provisions were introduced in 1995 to expand coverage in rural areas to those who work in farming, forestry, livestock raising or the fishery industry. The self-employed in urban areas later became eligible for the voluntary pension scheme. Now, workers of all firms are covered by a compulsory scheme and it was recently extended to informal workers, not in their capacity as workers but as regional subscribers, which means that they have to pay all the contributions themselves, with no payment from the employers. There are plans to change their status

to that of other workers. Under the new scheme, the number of beneficiaries is expected to increase twelve-fold over the next decade. Another problem is that the level of benefit remains low in the total income of the beneficiaries. Thus, retirees have to rely on other income sources such as an employment wage and family support (Ministry of Health and Welfare, 2000).

6.2.6. Health Care

The government's future aim of an advanced health care society calls for the establishment of lifetime health maintenance systems, an efficient health care service and promotion of the health care industry by revising relevant laws. The government envisages the average life expectancy to be 75 and the infant mortality rate to be under 7.0 percent by 2003. It also plans to cap the rate of chronic disease to about 24-25 percent. To help attain these goals, the government plans to cut the adult smoking rate from 35.1 percent to 30 percent and the obesity rate from 20.6 percent in 1995 to 15.0 percent by 2003 (Ministry of Health and Welfare, 2001).

Furthermore, the government is considering raising the health insurance premium and implementing measures to prevent unjustified claims on medical bills. Significant structural reforms are required to respond to the needs.

A new system incorporating corporate insurance (for wage earners) and regional insurance (for non-wage earners) has recently been launched by the Ministry of Health and Welfare with the aim of increasing coverage and improving management. Under

this new system, premiums will be set at 2.8 per cent of the monthly income of each policyholder, depending on their financial status. Consequently, those with higher incomes are expected to pay higher premiums. This new system also provides extended coverage of services, including those related to disease prevention and rehabilitation, whereas the previous system only covered treatment of diseases. The main idea behind this system is to combine the financial holdings of the 139 corporate insurance associations and the 188 branch offices of the National Health Insurance Corporation (Ministry of Health and Welfare, 2000). However, this option faces strong resistance from corporate insurance associations which refuse to support the high deficit of the regional insurers. The health insurance scheme is run by three groups: salaried workers, civil servants and teachers, and the self-employed. While the insurance scheme for civil servants and teachers will show a surplus this year, those for salaried workers and the self-employed are registering deficits.

6.3. Characteristics of the Korean Welfare System after the Crisis

Following the crisis, the Korean government has realised that, in existing welfare states, unemployment and income disparity are severe problems and excessive welfare expenditure has threatened government finance, driving it towards a budget deficit crisis. Also the government has been aware that over-generous welfare allowance has been criticised for diminishing welfare recipients' work incentive. In order to cope with these problems comprehensively, the government has attempted to find a new welfare model. In the establishment of a new welfare state model, several essential elements are to be considered: 'unemployment, income inequality, the financial crisis, stagnation and

deteriorating work incentives' (Chung, K. B. 2001, p.1). To address these negative elements, more comprehensive policy planning needs to occur.

6.3.1. Emergence of Productive Welfare Model

President Kim Dae-Jung has proposed a policy called 'productive welfarism'. He defines productive welfare as an ideology, as well as a policy, that seeks to secure a minimum living standard for all people, while expanding opportunities for self-support in socio-economic activities for the purpose of maintaining human dignity (Presidential Office, 2000).

The Korean government has put a high priority on promoting 'productive welfare', which means helping the needy while increasing their productivity. The government has been paying close attention to developing the nation's human resources by introducing various support programmes for society's most vulnerable citizens, including destitute workers and low income families. As a result specific policies have been implemented under the goals and principles of the productive welfare policy (Korean Information Service, 2001). Moreover, responding policies were among the swiftest and most comprehensive in Asia, including: (a) the expansion of unemployment insurance coverage and benefit duration; (b) increasing temporary public works programmes; (c) the expansion of basic livelihood protection, extending; and (d) introducing means-tested non-contributory assistance to the elderly poor. These experiences have promoted significant reform in welfare policy. The Minimum Standards Security Act was legislated in August 1999, marking a transformation to a human development and

welfare-to-work approach (Wolfensohn, 2001, p1). Beginning in October 2000, food, clothing, housing, education, and healthcare are subsidised through cash and in-kind transfers for those households who do not meet the minimum (income-based) living standard, with benefits linked to participation in labour programmes such as public works and job training for those able to work.

President Kim Dae Jung's vision of a system of productive welfare is made against the background of the serious financial crisis, which started at the end of 1997 and brought the impressive economic growth record to a sudden and unexpected halt. The crisis forced the government to agree to a rescue package with the IMF. Unemployment grew rapidly and peaked at more than 8 per cent in early 1999, and more than one million Koreans were thrown into poverty (OECD, 2000). The economic crisis hit vulnerable groups hard, increased the proportion of temporary workers and reversed the trend of steady improvement of income distribution, according to one recent analysis of the impact of the crisis (Kwon, S. 2001). As a social policy response, the government has introduced reforms in the areas of labour market policies and social safety nets, which helped the economy to renew growth, and the unemployment rate to fall.

A major focus of productive welfare lies in enhancing the people's standard of living through aspiring both equity and efficacy objective. An equity objective or an equitable distribution of wealth establishes a basic framework that ensures that every individual in the society is able to enjoy a minimum level of standard of living. Equally important, this minimum standard of living can be sustained or uplifted by means of stable economic growth that generates employment opportunities and constant income sources. In this respect, productive welfare can make a significant contribution to

mitigating the adverse effects of the crisis and thus to strengthening social integration (Kakwani and Son, 2001).

6.3.2. Four Pillars of Productive Welfare Model

Productive welfare is largely composed of four pillars: the establishment of a basic social safety net; the establishment of a self-support system for socially vulnerable classes; job creation, social investment, human development; and a streamlining and modernisation of the welfare system. All four pillars are essential to productive welfare and cannot be pursued independently, but should be closely associated, maintaining a mutually complementary relationship. In other words, effective self-support assistance can be provided only on the basis of a solid basic social safety net system. Human development and job creation will also be facilitated when society is well equipped with a basic social safety net system. Furthermore, self-support, human development, job creation and institutional streamlining can eventually reduce the social burden and function as building blocks for a stronger industrial foundation. In addition, these elements can foster the improvement of the basic livelihood security system of all people in the society. As mentioned previously, all four productive welfare pillars, when combined are, expected to create a synergistic effect, contributing to quality of life and national productivity improvement. Therefore, when all four programs are fulfilling their roles effectively, productive welfare supports social development and aims to balance resource demand and supply (Chung, K. B., 2001).

The establishment of a basic social safety net is the most fundamental prerequisite of Productive Welfare for promoting social solidarity. Centrepieces of the basic social safety net are basic livelihood security, basic welfare service provision, and human resource development.

The National Minimum Living Standards Security Act aims at protecting people's basic livelihood. In order to achieve this, a range of efforts is underway with a view to efficiently providing basic income, healthcare, and educational opportunities. The Korean government executed a comprehensive and general revision of the Livelihood Protection Act and introduced the National Minimum Living Standards Security Act in October 2000. Under this Act, the Government seeks to ensure that basic needs are met for all people living below minimum living standards regardless of their work capability. As result, the number of beneficiaries of Basic Livelihood Security reached 1.55 million, three per cent of the total population and three times the number of people covered before the Act.

The Act seeks to secure a 'home-based' society by implementing various programmes to strengthen family function and to ensure that people have the at-home welfare services they need. To achieve this goal, a multi-layered and organic social support system should be established to strengthen the family self-care system; at the same time, in the spirit of social solidarity, society should implement non-governmental caring mechanisms for those needing social protection.

To this end, family-support service delivery systems should be extended to complement diversified family arrangements. Introduction of a tax benefit system and incentives for protection providers should be actively reviewed for enhanced family protection.

6.3.2.1. Basic Social Safety Net

The social safety net has a three-tier structure (see Table 6.2). The first tier consists of four social insurance schemes including medical insurance, national pension, employment insurance and industrial-injury insurance.

Table 6.2. Productive Welfare Policy : Basic Social Safety Net

| Policies | Goals | Programmes |
|----------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|
| Basic Livelihood Security | Livelihood security | Basic income/health/housing/education Simultaneous and sufficient benefit provision required |
| Basic Service Provision | Homelike society | At-home welfare service, strengthening function Caregiver allowance |
| Overhauling of Social Safety Net | Social integration | Primary safety net (social insurance) – secondary safety net (social assistance) – tertiary safety net (emergency aid) |

Source : Chung, K., 2001.

The Korean government has introduced these social insurance schemes and through rapid expansion has established universal coverage of the social insurance scheme. The second tier represents social assistance for people under the poverty line. In Korea's case, the introduction of the National Minimum Living Standards Security Act has allowed all people living under the poverty line to receive social assistance benefits. The third tier is emergency aid to provide prompt assistance at the time of an emergency situation including natural disaster, war, economic crisis and massive unemployment.

Emergency food aid and medical services are good examples of the third tier of social safety net programmes (Chung, K. B., 2001).

6.3.2.2. Self-support Policies

Self-support policy can be divided into a counter-poverty measure on the one hand, and supporting instruments for the socially vulnerable such as the elderly, women and the disabled on the other (see Table 6.3). Although counter-poverty efforts are underway, to create community-based volunteer jobs, social jobs and self-support small businesses, more active and progressive measures are required to help the poor to climb out of the poverty trap.

Table 6.3. Productive Welfare Policy : Self-support Policies

| Policies | Goals | Programmes |
|-------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| Human Resources Development | Functional capacity Improvement | Vocational training, social education/lifelong education Caseworker retraining |
| Anti-poverty Measures | Poverty eradication | Community-based voluntary workers/self-support project/creation of social jobs Anti-poverty support |
| Productive Welfare Policy for the Elderly | Utilisation of elderly Expertise and skills | Job information service and small business incubator programmes Support for paid community volunteer workers |
| Productive Welfare Policy for Women | Utilisation of women Manpower | Women manpower development, public educare programmes, women manpower network |
| Self-support Policy For the Disabled | Increasing Self-support ability of The disabled | Education programmes, vocational training, and small business incubator programme, disabled workforce network |

Source : Chung, K., 2001.

Productive welfare policies for the elderly aim at utilising their expertise and skills. Related efforts include a number of programmes that provide support for elderly business start-ups, elderly job searchers, and paid volunteers. To make the policy more

efficient, a full-scale elderly workforce network is required. Productive welfare policies for women should be directed towards full utilisation of women's labour through the development of women-oriented programmes. Currently, a far-reaching network for women manpower and human resource development is required along with childcare assistance programmes and the promotion of the rehabilitation of all persons with disabilities by implementing a range of pro-disabled programmes. Vocational rehabilitation education and business incubator programmes are available to the disabled (Chung, K. B., 2001).

6.3.2.3. Job Creation and Social Investment

Job creation measures and social investment seek to counter unemployment, create social sector jobs, increase the incentive for people to work and create the impetus for greater labour flexibility (see Table 6.4).

Table 6.4. Productive Welfare Policy : Job creation and social Investment (Health/Education/Housing/Culture)

| Policies | Goals | Programmes |
|-------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Employment Network | Employment enhancement Increase work Incentives | Employment network, productive welfare network Wage-assisted employment |
| Creation of Social Jobs | Creation of Social Jobs that serve Public interest | Home helpers and community-based volunteer workers, community cleaning works, environment protection project, public project, public enterprises (co-operatives) |
| Investment in Preventive Healthcare | Health promotion/ Disease prevention | Health education centre/Health Expo/Health zone |
| Health and Welfare Industries | Knowledge-based, value-added Industry | high New medical instruments and drug development, food and cosmetics, and biotechnology & information technology |

Source : Chung, K., 2001.

Some of the existing measures include an employment network, productive welfare networks and wage-assistance employment. Also, a number of programmes are in place to create social jobs that serve public interest, including the home-helper project, community-based volunteer works, community cleaning, environmental protection works, public projects and public enterprise development. However, a greater investment is required to improve the performance of these programmes (Chung, K. B., 2001).

The social investment policy on preventative health care seeks to achieve increased productivity by promoting health and preventing diseases through health education centres, health expositions and health zones (Chung, K. B., 2001).

Health/welfare industry policy aims to transform the health industry into a knowledge-based and high value-added industry. A comprehensive set of strategies is under preparation with a view to fostering new innovations in drugs, medical instruments, food, cosmetics, information technology, and biotechnology. Health and biotechnology industries require further concentrated investment (Chung, K. B., 2001).

6.3.2.4. Improvement of System Efficiency

The existing welfare system will achieve greater efficiency with current efforts to stabilise social insurance finances, formulate a social insurance information infrastructure, build linkages among social insurance schemes, establish improved delivery mechanisms and invigorate performance-based management. Currently, a

comprehensive set of financial measures is under preparation to ensure long-term stability of social insurance funds (Chung, K. B., 2001).

As Table 6.5 shows, to ensure wider public accessibility to social insurance information, an array of new programmes is under development, among them an individual health/welfare care system, and the establishment of a national health care/welfare information infrastructure. The efficiency of the social insurance system will be further improved with additional measures to be taken to establish linkages among the four social insurance schemes (Chung, K. B., 2001).

To achieve increased efficiency in the service delivery system and health/welfare management, further efforts are required to initiate health/welfare service evaluation and implement performance-based management systems for social insurance agencies (Chung, K. B., 2001).

Table 6.5. Productive Welfare Policy : Improvement of System Efficiency

| Policies | Goals | Programmes |
|----------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| Financial Stabilization for Social Insurance | Financial balance | Financial stabilisation of the National Pension Financial stabilisation of the National Health Insurance |
| Informatisation of Social Insurance Sector | Information accessibility | Health/Welfare cards Health/Welfare information infrastructure |
| Linking Various Social Insurance Schemes | Efficiency of Management and Operation | Institutional link among the four major social insurance schemes |
| Performance-based management | Increased efficiency And responsibility in Management | Health/Welfare service evaluation system Performance-based management of social insurance organisations |

Source : Chung, K., 2001.

6.3.3. Debates on Productive Welfare Model

The Kim Dae Jung administration's social welfare policy has two noteworthy aspects. First, it draws attention to the relationship between globalisation and social welfare. Despite the general argument that the progress of globalisation undermines nation-states' autonomy and causes retrenchment of state welfare (Teepie 1995; Mishra 1999), Korea's social welfare has expanded amid rapid globalisation with the IMF's bailout funds. Korea is an uncommon case in which globalisation contributes to the expansion of social welfare and, therefore, the social welfare reform policy of the DJ administration is being watched with keen interest (Lee, H. K., 1999; Shin, 2000a, 2000b).

Second, by comparing the DJ administration's social welfare policy with the social welfare systems found in the welfare regimes of advanced nations, its characteristics may be identified and it may be possible to predict a shift to a specific welfare regime. Some contend that the DJ administration's social welfare policy has neo-liberal traits and it will mirror, in terms of actual policy content, the liberal welfare regime found in the United Kingdom or the United States (Chung, 2000; Cho, 2000). On the other hand, some note that the social welfare scheme pursued by the DJ administration has the institutional characteristics of the conservative/corporatist welfare regime in Continental Europe (Kim, H., 2000).

Existing research has reviewed the changes in the social welfare scheme under the DJ administration based on Esping-Anderson's typology. There are three different assertions on the characteristics of the Korean social welfare scheme and the welfare

regime it follows. First, the DJ administration's social welfare policy displays neo-liberal characteristics, as a result of welfare reform, a move towards a liberal welfare regime is expected. Second, the Korean social welfare scheme includes institutional characteristics found in the European conservative welfare regime. Third, researchers who put forward the East Asian welfare model - before the inauguration of the DJ administration - claimed that the Korean welfare system is similar to that of Japan. There have been crucial debates on the Korean welfare state regime's character among social policy commentators since the economic crisis of 1997 (Lee, H. K., 2002). Chung, M. K. (2002) and Cho, Y. H. (2002) have explored 'the accomplishments and limitations of the welfare reforms undertaken by the Kim Dae Jung government based on the recent debates about the main characteristics of the welfare reforms'. They argue that Korean welfare reforms in the aftermath of the crisis are a typical neo-liberal approach.

Kim Dae-Jung government's welfare reforms basically aimed at protecting the vulnerable generated by the massive neo-liberal economic restructuring. The government expanded the coverage of the insurance programmes and modernised the pre-modern public assistance programme. And other parts of the reforms, for example, the integration of corporative medical insurance programmes, have emphasised the solidarity principle of the welfare system. However, the overall content and consequences of the reforms still maintained the neo-liberal character emphasising the commodification of labour and the role of the market in welfare provisions. Thus, according to Esping-Andersen, welfare reforms can be characterised as a mix of conservative and liberal regimes. Thus, the Kim Dae Jung government's welfare reforms should be interpreted as having a partial continuity from the previous 'developmental welfarism' rather than a 'paradigmatic shift' completely broken off from the past (Chung, M. K 2002, p.161).

Cho Y. H. and Chung, M. K. suggest 'an alternative regime type' in order to better explain the characteristics of the Korean welfare system including those of some East Asian states such as Japan and Taiwan' (Cho, Y. H. 2002; Chung, M. K. 2002).

As Kim, Y. B. points out, there are four arguments about the typology of the Korean welfare state. They include the Asian/Confucian type, the hybrid type, the liberal type and the conservative type. He concludes that that the nature of Korean welfare reforms is more of a Conservative Coporatist model.

The three arguments do not fully explain the characteristics of the Korean Welfare State. First, the Asian/Confucian argument confused the temporal characteristics due to the immaturity of the Korean Welfare State with a structural one. Second, the division between insider and outsider which the Hybrid argument stresses, would not likely be one of the structural characteristics of the Korean Welfare State because after the economic crisis, the number of the insured under the social insurance increased rapidly. Third, the low expenditure level which the Liberal argument depends on, stems not from the institutional characteristics but from immaturity of institutions (Kim, Y. B. 2002, p.108).

He insists that the three arguments mentioned earlier do not fully help to understand the main characteristics of the Korean Welfare State (Kim, Y. B., 2002).

In addition, Nam, C. S. (2002) agrees with Kim Y.B's argument.

Comparing the pre-crisis and post-crisis welfare system, this article finds that figure for the de-commodification have maintained low to medium level and trends of conservative stratification have been steadily strengthened and figure for familialism have remained very high. Based on these findings, this article argues that the characteristics of the Korean welfare system are closer to those of conservative welfare regimes. However, some anomalies of the Korean welfare system which are

not congruent with the characteristics of typical conservative welfare regimes should be approached from somewhat different perspectives from three regime theses (Nam, C. S. 2002, 202).

Kim, Y. B. (2002) emphasises that the DJ Government's welfare reform efforts were aimed at keeping and protecting the right of the poor and isolated to live by re-enforcing state responsibility.

The social welfare policy of the Kim Dae Jung administration leans towards state welfare, which stresses the state's responsibility for welfare, and as a consequence of recent social welfare reform, the Korean social welfare scheme is a combination of institutional characteristics of various welfare regimes (Kim, Y. M. 2002, p.108).

There are many important unanswered questions in the debate on the Korean welfare regime (Kim, Y. M., 2002). Interestingly enough, all of them share the same analytic framework, i.e., that of Esping-Andersen's three world typology. Nevertheless, their conclusions vary widely. Esping-Andersen's frame of analysis should be revised, if not replaced, by a new frame, embracing the development of the new global economy. And the experience of Korea, not only in economic growth but also in social transformation, is indeed so unique and condensed that it has to be incorporated into the study of welfare regimes in general (Lee, H. K., 2002).

In this respect, Holliday (2000) has attempted to add a fourth criterion to the three Esping-Andersen's three worlds typology. He has argued that Korea can be placed in the fourth criterion called 'a productivist world of welfare capitalism'. There are two central aspects of the productivist world of welfare capitalism. These are: 'growth-

oriented state and subordination of all aspects of state policy, including social policy, to economic/industrial objectives' (Holliday 2000, p.708).

6.3.4. Social Policy under the Economic Recovery and Stabilisation Strategy

As Holliday (2000) has argued, Korea could be said to have a productivist welfare regime where social policy is subordinated to economic policy. This, of course, is not unique to Korea. Indeed, within this generic welfare regime, Holliday argues that Korea, along with Japan and Taiwan, is in a developmental-universalist stage of development, where the state underpins market and family provision with some universal programmes, where it sees those provisions failing (Holliday, 2000). As Holliday goes on to argue this is mainly to reinforce the elements of production within society. Certainly, from 1960 to 1987, Korea's welfare seemed to comprise an authoritarian developmental state with a residual 'competition-compatible' form of social policy. With the emphasis upon developing human capital for the benefit of the economy, the social ministries were placed in a subordinate position in relation to the Economic Planning Board. This authorised state funding only in areas of productive social investments – in particular education (Shin, 2000b). The government stepped back from taking any more interventionist a role in social development. As a consequence, government expenditure on social development was minimal in the lead up to the economic crisis of 1997 (Kwon, S., 2001).

Korea's experience illustrates 'the importance of economic growth for poverty reduction, but the crisis underscored the need to achieve "balanced"¹ growth to maximise the gains to the poor and vulnerable' (Wolfensohn 2001, p.3). However, another important consideration is the impact of the international economy on the long-term pattern of the co-ordinating mechanism in Korea and accordingly on the pattern of welfare state development. The Korean economy has been further incorporated into the international economy through market opening, particularly financial market opening. The impact of the international economy has been ambivalent in the sense that it has reinforced the existing interrelations of economic actors on the one hand, while on the other hand it has opened up a new chance to change them. These mixed results can be traced back to domestic politics; which is to say, the interrelations among state, business, and organised labour.

Much of the impressive national response to the crisis stems from its public policy decisions. Structural reforms have made Korea's economy more competitive and market-driven. Significant progress has been achieved towards stabilising the financial system, including liberalising capital markets and foreign investment and strengthening the institutional framework for corporate governance. Market discipline in an environment of transparency plays an increasingly important role' (Wolfensohn 2001, p.2).

The Kim Dae Jung administration started with the IMF intervention at the end of 1997 and set its plans based on a free-market economy with the ideology of neo-liberalism. As noted earlier, its welfare policy emphasised a balanced welfare state, productivist

¹ This involves finding a balance between a competitive economy and a caring society, striving to include those who are not able to compete adequately, helping people to improve their opportunities and support themselves. This notion of balanced, quality growth forms the foundation of the productive welfare concept in Korea. Balanced growth also underpins the recommendations of the current World Development Report on attacking poverty (Wolfensohn 2001, p.3).

welfare, and welfare pluralism (Chung, 1998). These welfare policies are generally seen as appropriate for highly advanced countries rather than a country like Korea, which has a very low level of social welfare provision. That is, if the policy were implemented with the ideology of neo-liberalism, the responsibilities of nation's welfare system would have been evaded even during the recession.

6.3.5. The Neo-liberal Approach to Social Policy?

Analysing the social welfare policy of the early period of the Kim Dae Jung administration, Chung Mu-Kwon notes that while this administration's welfare policy has some radical aspects compared to past administrations, 'when it is seen from the broader context of neo-liberal restructuring, it may be more fair to say that it just does not conflict with neo-liberal values in terms of the contents of social policy reform and its outcomes' (2000, p.354). He states that some may interpret the extension of social insurance coverage and the enactment of the National Basic Livelihood Security (NBLS) Act under the DJ administration as measures to expand the safety net mechanism needed for the social security system to have a favourable neo-liberal framework. He warns against the possibility of reducing the Kim administration's social welfare reform to establish the safety nets recommended by the World Bank.

Acknowledging some neo-liberal characteristics in the DJ administration's welfare reform, some researchers further diagnose that the Korean welfare regime is moving towards a liberal welfare regime. To substantiate their argument they raise several points: the 'productive welfare' initiative focused on 'social assistance for low-income

earners and not the public in general; the main interest is given to resource distribution through the market rather than expansion of income transfers and social security; the role of NGOs, local communities, and private companies as providers of social welfare increases dependency on the market' (Cho 2000, pp.99-100).

Esping-Andersen (1999) points out some characteristics of a liberal welfare regime in his recent book, *Social Foundations of Postindustrial Economies*. Firstly, liberal policy is residual in the sense that social guarantees are typically restricted to 'bad risks'. (More weight is given to needs-based social assistance programmes than rights programmes.) Secondly, it is residual in responding to risks at the societal level. (The United States does not provide national health care, child allowance or maternity benefits.) The third characteristic is its encouragement of private welfare through the market (Esping-Andersen 1999, pp.75-6).

Gilbert (2001) argues that the productive welfare model is largely, though not entirely, concerned with economic considerations - employment, productivity, and self-support. Although DJ Welfarism (productive welfare policy) also discusses the need for policies devoted to the care of those unable to work, clearly the repeated thrust of this approach is to make people self supporting. Indeed, in the words of the Presidential Committee for the Quality of Life, 'the objective is to include everyone in the workforce, regardless of ability, disability, deprivation, or privilege' (Gilbert 2001, p.5).

However, the unemployment policies introduced after the economic crisis emphasised workfare, where the main idea is to support only those who are able to work. The possible consequence of workfare is not to take people out of poverty by providing the

opportunity to participate in the labour market, but to ensure that even eligible welfare recipients will lose their right to receive benefit if they do not work. Thus, rather than constructing a social safety net, it is apparent that the welfare plan would work only for those who are able to work, while excluding those who are in need of social care and support for a while to be able to work.

Furthermore, in the aftermath of the economic crisis, the government has tended to stress the greater role played by family members, particularly women, in providing care for their elderly relatives and the desirability of multigenerational households over nuclear families. A similar emphasis on the caring roles of the family and community is also seen in the Korean state's renewed public emphasis on the country's Confucian cultural tradition.

6.3.6. Continuity of Fostering Confucianism and Family Responsibility

Social policy has changed to become more egalitarian, in the wake of the economic crisis in 1997. In addition, there have been many recent social policy reforms to cope with social problems caused by the economic crisis. However, how much such policies can mean in practice for families in Korea remains an open issue, since Confucian traditions with regard to family obligation remain strong.

Sung, S. (2003) has argued that Confucian tradition in the woman's role remains too strong an influence. Confucian welfare regimes are deeply gendered, especially in terms of women's responsibility for unpaid care work. Thus Confucian traditions continue to

have an influence on working women's experience of reconciling paid and unpaid work as well as shaping of state policy. Sung has explained more detail about care work:

The Confucian impact on state policy can be seen most clearly in care provisions (or rather in the lack of them). Care work is mainly regarded as a family responsibility, which directly leads to its being the women's responsibility. In terms of childcare, the number of private nurseries is much greater than the number of public ones. The government tries to impose responsibilities on employers to establish nurseries in the workplace for working women, which may have the result of discouraging the recruitment of female workers. Although the government provides a subsidy to employers who establish workplace nurseries, the amount of subsidy is insufficient to encourage employers actually to establish them (Sung, S. 2003, p.356).

As far as the care for the elderly is concerned, the government still emphasises the Confucian virtue of 'filial piety'. The virtue itself is a good one. However, if the government places an emphasis on Confucian virtue in order to avoid responsibility for care for the elderly, emphasising the virtue can result in attributing responsibilities to families and individuals from a morally unsound governmental position. Certainly it is the case that unpaid care work seems neglected in Korean state policy and is considered the responsibility of women. To be sure, the problem of ignoring the issue of unpaid work in social policy has not been peculiar to the Korean government.

After the economic crisis of 1997, the Kim Dae Jung government emphasises improving women's rights to work by increasing the number of women workers in the public sector. However, caring for dependants still remains a family responsibility.

6.4. Summary

This chapter has explored the government's policy responses after the economic crisis of 1997. Since the economic crisis of 1997, Korea has experienced a rapid expansion of the social welfare provision following a series of reforms. These reforms went beyond the functional minima necessary to deal with social problems caused by the economic crisis. The changes in the social security system in Korea in the wake of the financial crisis are paradoxical from the perspective of globalisation enthusiasts. The social security reforms have proceeded as a crucial measure in coping with the soaring unemployment as well as alleviating the insecurities associated with structural adjustments.

These reforms have not been limited to the establishment of the social safety net. Rather, they have been developing towards a more redistributive and comprehensive welfare system. In addition, the economic crisis changed the socio-economic conditions so that no one could be sure of avoiding unemployment. This in turn changed attitudes towards social solidarity and the role of the state in social welfare provision.

However, the government has tended to stress the greater role played by family members, particularly women, in providing care to their elderly relatives, and the desirability of multigenerational households over nuclear families. A similar emphasis on the caring roles of the family and community is also seen in the Korean state's renewed public emphasis on the country's Confucian cultural tradition.

In the following two chapters the development of mental health policy in Korea will be discussed in terms of both cultural and structural influence, in relation to the emergence of mental health problems and the subsequent government's responses.

Chapter 7. The Emergence of Mental Health Policy during the Industrialisation Period

The previous two chapters have outlined the implications of the radical and exceptionally rapid changes in the demography, economy and social formations of Korea over the last few decades for the care and support of its dependant people. With the creation of an industrial society, the concentrations of urban population, the urgent and massive social problems arising from phenomenally rapid urbanisation, the undermining of more traditional family and community systems of social support and control, the problems of welfare have become a societal rather than a family problem.

Nevertheless, the development of social policy continues to be facilitated by Confucian values. In Korean society, citizens are under strong moral and, sometimes, political pressure to keep familial problems within the family and to abstain from resorting to social or governmental measures in an effort to meet familial needs (Kim, 1990; Chung, 1991).

The political structure's emphasis on economic development makes it difficult to moderate any social stress factors through the development of a countervailing social welfare infrastructure. There has indeed been a deliberate governmental strategy not to develop a supporting social infrastructure or a modern welfare state package of social services and income policies/programmes such as might assist dependant people and their informal caregivers.

The thrust of this chapter is on policy responses to perceived social problems related to mental health (i.e. the increasing number of people with mental health problems) and the way in which the problems of mental health were individualised within families. Mental health policies during the industrialisation period were informed and shaped by a strong Korean cultural tradition and repeated affirmation of the values and practice of Confucianism.

This chapter is divided into five sections including the summary, the first section outlines the brief history of mental health care prior to the 1960s. Section two tries to examine the relationship between social changes and mental health during the industrialisation period. Section three explores the government's response to the problems of mental health and then in section four the basic features of the mental health policy that was informed and shaped by Korean politics and culture during the industrialisation period are identified.

7.1. The Brief History of Mental Health Care Prior to the 1960s

There was a traditional attitude towards those people with mental health problems before the Western psychiatric model was introduced in Korea. Traditionally, mental health problems were not perceived as medical problems, but as a spiritual problem or one of social relations, often ascribed to possession such as by foxes and badgers (Lee, 1988). The traditional medical treatment in the ancient period (2333 B.C. – 108 B.C.) of Korea considerably emphasised physical treatment as we have seen in the records on the

psychotherapy cases dealt with by non-physicians. In Korea the differentiation of a physician from a non-physician, empirical rationalism from shamanism¹ existed in the earlier period (2333 B.C. –), since one of ancient Korean history books entitled *the Reminiscent History of Three Kingdoms* recorded psychotherapies conducted by Buddhist monks. Similar to the West, in the history of Korean psychiatry both religious healing and empirical healing cannot be overlooked, since Shamanistic healing methods² for chronic disease flourished (Lee, 1988).

A range of techniques was employed to rid individuals of possession, including turning to shamans and purification. Healing in terms of Korean shamanism belongs to a type of healing in ecstasy and healing through strong affective experiences. Organised religions were also turned to for assistance, including Buddhism, which came to Korea from China in the fourth century A.D. At times Buddhist temples provided those with mental health problems with places of refuge, and some of the temples appeared to be popular especially for their capacity to assist. In addition, families were responsible for dealing with their mentally ill family members without any government-based assistance. For the most part, households were obligated to assist their own members. Constructing a locked room or cell at the family home to confine those with mental health problems was the most common method for dealing with them until the early twentieth century.

¹ In Korea, shamanism-earlier among Korean religions-continues to have a large number of adherents, often in combination with other beliefs. Shamanism recognizes a myriad of spirits who can work for good or ill. They must be propitiated to avoid evil, cast out if need be, and solicited to ensure success and fortune. Families, houses, natural objects all have spirits. Many ancient customs have to do with winning the spirits' favor or averting their wrath. In Korea (unlike in Japanese Shinto, which in some other ways is similar), there are few large shamanistic shrines or groups of practitioners. However, Buddhist temples typically have a small building dedicated to the "mountain god," implicitly a shaman deity, and some villages and families have modest shrines.

² The adepts of shamanism are mostly women, known as *mudang* or *manshin*, who inherit their possession or otherwise demonstrate special communication with the spirits; they are retained by individuals or families in time of special fortune or special trouble. Often they perform a lengthy ceremony called *Kut*, including costumes, song, and dance, to communicate with the spirits and sometimes to be possessed by them.

This was a common practice in Korea until very recently and it is similar to practices in the West during the pre-and early industrial period. As can be seen from the treatment of Mrs Rochester in Jane Eyre written by Bronte.

Western medical theory first came to the attention of Koreans when Adam Shall, a Jesuit missionary, introduced Galen's physiology in 1645³. Preventive measures against epidemics were embarked upon in the 1880s and in 1885 Kwang Hae Won, a royal hospital, was founded and the following year a medical school was established by the government, but psychiatry courses were not offered at that point. A government newsletter reported in 1910 that a course on psychiatry was first established to treat people with mental health problems. However, only in the 1930s was western psychiatry (German psychiatry was introduced by the Japanese) known to a few Koreans and in the 1940s several Korean students at the Medical College of Kyungshing Imperial University embarked on an ambitious beginning in the study of western psychiatry. If we regard this start as the true starting point of western psychiatry in Korea, Korean psychiatry only has a 60 year history. Even during these periods western psychiatry had hardly enough time to settle down mainly due to the loss of a number of psychiatrists, who were either missing or dropped out of school during the Korean War (1950-1953). Only an introductory course on the outline of German descriptive psychiatry and the operation of the classroom-within-the clinic method were continued during this period⁴.

³ However, it was 100 years later that the vaccination for smallpox seemed to be practiced by Jung Yak-Young.

⁴ The studies on brain pathology, psychoanalysis, social psychiatry, medical history, drug abuses, Korean folklore and culture were also taught during this period.

There were some ideas and movement towards formulating mental health law in Korea after the Japanese Colonial Period. Prior to Japanese rule Korean psychiatric professionals had to learn Japanese mental health laws and systems. This legislation however did not apply to Korean people in general. In the aftermath of the Japanese occupation of Korea, many psychiatric professionals expected the establishment of a mental health law to settle the practice of modern techniques for prevention and cure of mental illness. There were, however, some difficulties to the enactment of the law because of political turbulence and the Korean War. During the Korean War (1950-1953), Korea experienced a system of military mental health hygiene, which introduced American psychiatry, skill, and knowledge of mental health into Korea. The introduction of the American psychiatric model influenced the development of the mental health system and expanded the psychiatric manpower. It was considered a golden opportunity to promote a mental health system and tackle mental health problems after the Korean War. While the WHO campaigned with the movement of World Mental Health Year, the Korean government established the Mental Health Consultative Committee to formulate a mental health act bill after reviewing the Japanese Mental Hygiene Act. Around 1958 a group of Korean psychiatrists who had studied in the United States, played an important role in providing a turning point in the development of psychiatry in Korea. Though the trends of European psychiatry were introduced into Korea in the latter part of the 1960s and the early 1970s, still Korean psychiatrists pay much attention to the trends in American psychiatry.

Generally, Koreans treat people with mental health problems as abnormal and tend to keep them at a distance. Up to the 1960s, there were fewer people with mental problems

in Korea. Accordingly, the government's response to the problems of mental health was relatively passive. During this period, families were still left to deal with the upset their family member generated when the prevailing methods did not ameliorate those with mental health problems.

7.2. Social Changes and the Emergence of Mental Health Policy

There has been an argument that changes in social factors are commonly associated with the increased prevalence of mental health problems although there are considerable problems involved when attempting to determine the importance of social factors in the aetiology of mental health problems (Corney, 1985). Also Corney (1985) pointed out that 'chronic social difficulties such as financial hardship, social isolation, migration and low social class have been shown to be associated with an increased prevalence of mental illness' (p.28). In this regard, it could be argued that Korean people experienced psychological distress and mental health problems due to considerable social changes during the industrialisation period.

Behaviourists tend to attribute the relationship between social change and stress to the speed of cultural change imposed on people, the gap of change expected between the traditional culture and the new culture, the strengths available, and the coping patterns utilised by the society in dealing with the social change (Tseng et. al., 2001). Based on this, it is possible to predict that Korean society will have had a pattern of adjustment to the social improvements they were making, which may have led to outcomes that may be similar to those in Western societies.

7.2.1. Industrialisation and Mental Health

As mentioned in Chapter 3, the social and economic changes associated with industrialisation are important factors contributing to rise of the asylum in nineteenth century Britain. Also, Kathleen Jones (1960) saw industrialisation as a causal factor influencing the prevalence of mental health problems:

In the first half of the nineteenth century, the tide of industrial change brought new wealth and new opportunities to a few, but squalor and hardship to many. The social problems with which small rural communities had dealt casually, but on the whole effectively, became acute in the towns, where families were crowded together in conditions of dirt and disease and despair; but industrialisation, if it intensified social distress, also provided the means of dealing with it. (Jones 1960, p.1)

In the same vein, in the 1970s and 1980s, there was a rapid social shift due to industrialisation and urbanisation and an increase in problems caused by industrialisation and urbanisation. This led to Korean psychological conflict and the phenomena of anomie. Lee, B. (1982) argued that cultural changes caused by industrialisation and urbanisation play a great role in mental health.

Those who migrate from the countryside to big cities and who live in the progress of drastic industrialisation and urbanisation. The drastic changes in the value system, in family relations, in the roles of man and woman also have a serious effect on mental health (Lee, B. 1982, p.26)

Moreover, modernisation, accompanied by demographic changes, urbanisation and industrialisation, contributed to changes in Korea's family structure. These trends, plus other modernisation changes such as the increased nuclearisation of families, were

indicative of the fact that the availability of households that care for their relatives who have mental health problems also shrank (Palley, 1992).

In order to understand how and why the Korean mental health policy has been developed, we need to examine the socio-economic changes in the aftermath of industrialisation. Rapid industrialisation, modernisation and urbanisation brought about enormous socio-economic changes. These changes include urbanisation, demographic changes, economic growth, changes in industrial structure, and export-oriented development strategies. As a result of this, a range of behavioural and mental health problems appeared in Korea. There was an increase in the incidence and prevalence of schizophrenia, dementia, depression and other neurological disorders. The disruption of traditional family ties and roles including a move away from the tradition of the extended family resulted in an apparent increase in alcohol dependence, unsanctioned, hazardous and harmful drug use and suicide. The impact of family disintegration emerged as highly visible public health problems (WHO, 2001).

7.2.2. Social Indices associated with Mental Health

As noted, socio-economic changes due to industrialisation are more likely to be one of the crucial factors which have contributed to mental health policy making in Korea. In addition various social indices resulting from socio-economic changes urged the government to introduce a mental health care policy and system. There is no simple way to describe the mental health of a society as a whole, but these include mental health

problems that are closely related to socio-psychological conditions, such as the disruption of families by divorce, substance abuse and delinquent or suicidal behaviour.

7.2.2.1. Gradual Increase in Divorce Rates

Although the importance of the family and marriage was emphasised in Korean society in the past, there are indications that, in some instances, the family system has undergone stress and marital relations are vulnerable, as reflected in the gradual increase in divorce rates. It is more likely to be important that divorce does not necessarily indicate a decline in mental health. It may merely reflect a common, socially accepted resolution for unsatisfactory interpersonal relations between spouses. Yet, because the crude divorce rate is objective statistical information that is readily available for cross-societal examination, it will be used here as one possible indication of the stress associated with marital life. According to the Annual Report on the Vital Statistics, the crude divorce rate increased from 0.5 per cent in 1975 to 2.5 per cent in 1997 (National Statistical Office, 1998).

As show in Table 7.1, several factors have contributed to the gradual increase in divorce rates in Korea, where families traditionally have been highly valued. In the past, marriage was regarded as the backbone of the family. It was considered that, once they married, a husband and wife should maintain their relationship for the rest of their lives - whether the marriage worked or not. However, this view is changing. Gradually, emotional satisfaction has become more important than marital bonds. This is particularly true among those who were married by arrangement while they were young

and have been forced to maintain their marriages for the sake of their children, even though their husband-wife relationship has not been satisfactory.

Table 7.1. Composition by Previous Divorce Status : 1990-1997

| Year | Problems in Relationship with spouse | Economic Problems | Family Discord | Health Problems | Others |
|------|--------------------------------------|-------------------|----------------|-----------------|--------|
| 1990 | 81.5 | 2.0 | 3.4 | 1.5 | 11.5 |
| 1991 | 81.9 | 2.0 | 3.5 | 1.4 | 11.4 |
| 1992 | 83.1 | 1.9 | 3.1 | 1.4 | 10.5 |
| 1993 | 81.7 | 2.3 | 3.1 | 1.1 | 11.8 |
| 1994 | 80.4 | 2.8 | 2.7 | 1.1 | 13.0 |
| 1995 | 80.1 | 3.0 | 3.0 | 0.9 | 13.0 |
| 1996 | 80.5 | 3.5 | 2.8 | 1.0 | 12.2 |
| 1997 | 79.4 | 4.2 | 2.9 | 1.0 | 12.4 |

Source: NSO (1998) *Annual Report on the Vital Statistics*, Seoul, Korea, NSO.

A higher prevalence in rates of mental illness among the separated and the divorced has been found by many studies (For example, Goldberg and Huxley, 1980). This may be due to depressed or anxious individuals being more prone to marital disharmony or due to marital disharmony and a lack of a supportive intimate relationship increasing an individual's vulnerability to the effects of life-events (Corney, 1985).

7.2.2.2. Rapid Increase in Substance Abuse and Crime Rates

Substance abuse within a society is measured by the recorded number of people arrested for substance abuse - mainly for defined illegal substances. It must be cautioned that such figures are very much influenced by political attitudes towards abusive behaviour, including patterns of law enforcement. These go beyond the general social attributes of substance abuse, including social stability, economic condition, availability of substance

supply, and people's attitudes towards the abuse of certain substances. As Table 7.2 demonstrates, the rate increased steadily from the 1980s to 1996.

Table 7.2. Substance Abuse: Annual Number of People Arrested by Rate per 100,000 population or percentage of user in the past year.

| Year | 1982 | 1984 | 1986 | 1988 | 1990 | 1992 | 1996 |
|-------|------|------|------|------|------|------|------|
| Rates | 1.8 | 1.8 | 2.3 | 4.1 | 4.1 | 4.2 | 5.2 |

Source: NPA (1997) *Annual Statistics of Police*, Seoul, Korea, NPA.

In addition, the safety that is enjoyed in a society is another index that reflects its quality of life and mental health. A high rate of criminal behaviour is an indication of safety problems in a society. A steady rise in crime rates was noted in Korea from the 1970s to 1995 (see Table 7.3.).

Table 7.3. Annual Crime Rates Per 100,000 Population

| Year | 1970 | 1975 | 1980 | 1985 | 1990 | 1995 |
|-------|-------|-------|-------|-------|-------|-------|
| Rates | 3,224 | 3,528 | 3,812 | 4,081 | 4,287 | 4,509 |

Source: NPA (1997) *Annual Statistics of Police*, Seoul, Korea, NPA.

7.2.2.3. Vicissitude of Suicide Rates

It is said that there are many causes of suicidal behaviour. A severe mental health problem including major depression, is one. Yet, many suicides are caused by emotional problems relating to stress in life. It has been illustrated that the annual suicide rate will fluctuate in association with the social situation. Thus, annual suicidal behaviour can be

used as one rough index of the mental health of a society. As completed suicides are easily recognised, annual data is relatively reliable, although social attitudes towards suicide and patterns of reporting such behaviour may influence the official data.

Among Koreans, the highest annual suicide rate was noted between 1965 and 1975 - one to two decades after the Korean War ended and the society was recovering from its impact. The rate was around 30 per 100,000 population, the highest in Asia. The rate declined gradually thereafter reaching 20 per 100,000 in the 1990s. Data from Korea indicated that suicide rates may rise when there is a rapid socio-economic improvement, supporting Durkheim's (1952) observation and theory that the suicide rate is high during economic booms as well as during economic depressions.

7.2.2.4. Increasing Number of People with Mental Health Problems

As previously explored, in the aftermath of industrialisation and urbanisation the number of people identified as mentally ill tended to rise over time (see Table.7.4). The prevalence of mental health problems increased prior to the economic crisis of 1997. Korean society moved towards urbanisation and industrialisation while experiencing rapid population increase. The rate of mental disability increased from 1.03 per cent (male, 0.87 per cent; female 1.19 per cent) in 1980 (Moon, 1981) to 1.45 per cent (male, 1.02 per cent; female, 1.88 per cent) in 1986 (Kim, 1988; Moon, 1981). In 1991 the Korean government estimated that there were 907,000 people (2.16 per cent) suffering from mental illness, of whom 105,000 people were considered to be in need of care and psychiatric treatment. It is difficult to estimate the numbers or the percentages of people

with mental health problems because of the widely accepted Korean culture of privacy and dignity. In 1989 there were 5,346 mentally retarded people who had been admitted to institutions for the handicapped (Ministry of Health and Social Affairs, 1990).

Table 7.4. Psychiatric Patients Institutions and Inmates : 1985-1995

(Unit : person)

| | Number No. of Institution | Admission | | Discharges | | | | |
|------|---------------------------------|-------------|-----------------|---------------------------|-------------------------|----------|--------|--------|
| | | Entrustment | No relatives | Surrender to relatives | Employment with care | Transfer | Deaths | Others |
| 1985 | 47 | 2,515 | 2,787 | 2,409 | 2 | 88 | 233 | 200 |
| 1990 | 74 | 3,138 | 1,192 | 2,973 | | 517 | 194 | 261 |
| 1995 | 75 | 2,556 | 544 | 1,808 | 166 | 552 | 179 | 228 |

Number of Inmates as of Year End

| | Sex | | | Age | | | |
|------|------------|--------|--------|------------------------|--------|----------------------|--------|
| | Both sexes | Male | Female | Less than 18 years old | | 18 years old or over | |
| | | | | Male | Female | Male | Female |
| 1985 | 10,719 | 6,479 | 4,240 | 41 | 39 | 6,438 | 4,201 |
| 1990 | 17,432 | 10,790 | 6,642 | 40 | 31 | 10,750 | 6,611 |
| 1995 | 18,182 | 11,182 | 7,000 | 11 | 10 | 11,171 | 6,990 |

Number of Inmates as of Year End

Symptom

| | Schizophrenia | Depression | Epilepsy | Mental Retardation | Senile drug addiction & etc |
|------|---------------|------------|----------|--------------------|--------------------------------|
| 1985 | 8,843 | 680 | 331 | 274 | 591 |
| 1990 | 14,176 | 838 | 551 | 521 | 1,346 |
| 1995 | 15,283 | 575 | 449 | 608 | 1,267 |

Source: MoHW (1997) *White Paper of Health and Welfare*, Seoul, Korea, MoHW.

Since the government did not provide reasonable benefits for people with mental health problems and the benefits of the institutions are limited, those who were rich or who could manage to sustain a basic living hesitated to send a family member to the welfare facilities for the handicapped. Therefore, it can be said that people with mental health problems who were admitted to the institutions are only those people who have no guardian (family and relatives) and are unable to maintain their livelihood (Kim, 1994). It means that family care was the main source of mental health services.

In this section, the range of social indices related to mental health have been demonstrated in order to understand mental health policy making in Korea. It appears to be supported by the fact that these various social indices, owing to the rapid socio-economic changes, which the Korean government began to introduce its mental health care policy and system, are a crucial impetus. In the following section, how the socio-economic changes affected the family structure and family care for people with mental health problems will be explored.

7.2.3. The Impact of Social Changes on Informal Care by Family

Demographic, social, economic, and cultural changes associated with modernisation have affected the care needs of people with mental health problems and the family's capacity to provide care. The growing participation of women in the labour market is likely to affect the availability and the capacity of family carers, particularly women carers. Most of the trends have resulted in or are likely to result in a weakened capacity of the family to provide care for people with mental health problems. The Korean literature has reached a similar conclusion: although family support and care for people with mental health problems has decreased compared with past levels, the tradition of family care still remains strong in modern Korean society, but tends to indicate that it will be weaker in the future (Suh, 1999; MoHW, 2000).

There has been a considerable impact on informal care by families with industrialisation. This remarkable social change affected those who were most vulnerable in the community including people with mental health problems.

The advancement of industrialisation has weakened the informal care by families, and the demand for care has increased steadily along with people with mental health problems.

(Suh 1999, p.1).

In addition there was a considerable change in industry after industrialisation. This change heavily influenced informal family care.

With the advancement of industrialisation, there was a shift away from working at home towards waged work in the secondary and tertiary industries and this shift impacted on the preconditions of family care.

(Kim, D. 1990, p.409).

The industrialisation of Korean society has led to a dramatic upsurge in the need for care, whereas, at the same time, its capacity for informal care has decreased at a rapid rate.

Korean economic development has proceeded at a rapid rate for the past two decades but with neglect to some areas of human development, especially in the cases of mental illness. The very process of industrial development and the unavoidable social changes are, in fact, important factors in the overall rise of mental illness in many NICs.

(Suh 1999, pp.1-2).

Industrialisation in the post-war period profoundly changed the employment structure, and rural-to-urban migration of the population brought about an increase in the number

of nuclear families. These developments undermined the preconditions underscoring the traditional approach of informal care.

Due to the process of industrialisation and urbanisation some important family functions, such as health care, education and some kinds of domestic work, have been taken away from the family system and taken on board by other sectors. The increase of care needs and the decrease of the capacity for informal care is an outcome of modernisation.

(MoHW 2000, pp.2-3).

In Korea, it is predicted that the influence of traditional values will be much weaker in the future. The informal caring relationship and the capacity for informal care is inevitably declining with the advancement of industrialisation and the economic crisis of 1997. Therefore, it will become more difficult to rely so much on the informal sector and the heavy care load is likely to generate serious antagonism in the informal caring relationship.

The informal caring relationship tends to be more antagonistic and the younger generation and women are rebelling against traditional styles of informal care. Therefore, if the government wishes to avoid a crisis, it is necessary for it to have a wide range of options in order to retain residual welfare provision for vulnerable groups such as the elderly, people with mental health problems and the other people in need.

7.3. Government's Responses prior to the Economic Crisis

The Korean government's response to the issue of mental health care was likely to be

passive before the 1960s, and this was partly due to the relatively small numbers of people with mental health problems in the total population. Rapid social changes, however, suggest the significance of planning social policy for supporting people with mental health problems and their families in the long term. Moreover, demographic and social trends were likely to bring an imbalance between the demands for the care of people with mental health problems and the availability of carers responding to such demands. Policy considerations arose in the field of mental health through the process of Korean economic development and national financial growth. Therefore, a more positive mental health policy was expected to develop. In effect, Korea had a greater concern for mental health policy than ever before (Suh, 1999).

7.3.1. Policy Developments during the 1970s and 1980s

As mentioned in Chapter 5, Korea experienced a period of industrialisation and urbanisation through the 1970s and 1980s. There were people who suffered mental problems even in an agrarian society, but their numbers were few. They were embarrassed by the inhumane treatment they received when they appeared in the community, instead of being treated by a mental health service. Since the 1970s, however, because of accelerated industrialisation and urbanisation in Korea, the number of patients in the mental health field increased. Like many developing countries, in Korea, care programmes for individuals with mental health problems had a low priority. Provision of care was limited to a small number of institutions – usually overcrowded, understaffed and inefficient - and services reflected little understanding of the needs of ill individuals or the range of approaches available for treatment and care. Prior to the

1980s there was no psychiatric care for the majority of the population in Korea, the only services available were in mental hospitals (Suh, 1999).

In 1984, the government attempted to formulate national plans for mental health services, develop human resources and integrate mental health with general health care, in accordance with the recommendations of a 1974 WHO expert committee. The government adopted the principles of the protection of persons with mental health problems and the improvement of mental health care, emphasising protection of the rights of individuals with mental health problems. It was recognised that violation of human rights could be perpetrated both by neglecting the patient through discrimination, carelessness and lack of access to services, as well as by intrusive, restrictive and regressive interventions.

In addition, the Korean government took an interest in social welfare and mental health as the GNP per capita rose from \$82 in 1961 (Economic Planning Board, 1988) to reach \$2,826 in 1987 (Ministry of Health and Social Affairs, 1987). As mentioned earlier, during this period, the social changes were rapid because of industrialisation and urbanisation and Korea experienced increasing mental health problems due to both psychological conflict and the phenomena of anomie. Therefore, the Korean government established three national mental hospitals, eight city and provincial mental hospitals, and supported 77 mental sanatoriums. In those facilities, 58 medical doctors and 48 doctors were employed in national facilities. The Korean government provided treatment to patients through 1,950 beds in national mental hospitals and 1,758 beds in public mental hospitals (Kim, 1989).

Moreover, the government built facilities and placed personnel, having developed an interest in that policy area. Also, private organisations established mental sanatoriums for mental patients and operated them with governmental support, and private organisations and religious organisations established private institutes where mental health patients were accommodated and treated (see Table 7.5). Because Korean society become much more complex and mental patients increased, there was another social problem. In 1983 human rights became an issue for patients in the private institutes and brought about recognition of problems related to treatment concerns for mental illness. The Medical treatment and management system was supposed to provide for primary and secondary treatment. Health centres, consultation offices, and a psychiatrist's office were in charge of the diagnosis of patients, consultation, treatment, and management of outpatients.

Table. 7.5. State of Medical Care System for Mental Patients, 1989.

| Division | | No. of Facility | No. of Bed | % | |
|-------------------|-----------------------------------------|-----------------|------------|----|-------|
| Total | | 446 | 29,910 | | |
| Special Beds | Sub Total | 373 | 12,863 | 43 | |
| | Special Mental Hospital | National | 3 | | 1,950 |
| | | Public | 2 | | 500 |
| | | Private | 16 | | 3,920 |
| | Dept. of Psychiatry in General Hospital | | 118 | | 4,205 |
| | Hospital | | 229 | | 1,230 |
| Public Sanatorium | | 5 | 1,058 | | |
| Sanatorium | | 77 | 17,047 | 57 | |

Source: MoHSA (1989) *White Paper of Health and Social Affairs*, Seoul, Korea, MoHSA.

There were six national mental hospitals, special mental hospitals, and mental sanatoriums, which provided secondary treatment and were supposed to take charge of rehabilitation, training, treatment, and the rejoining of society based on their respective functions (The Sixth Socio-Economic Plan, 1986). According to statistics prepared by

the Ministry of Health and Social Affairs, there were 10,803 beds for mental patients, although the number of inpatients was 37,698 (Ministry of Health and Social Affairs, 1990). So there was a great shortage of beds, and very poor conditions. Table 7.5 shows that as late as 1989, there were 373 special hospitals which had 12,863 beds and 73 sanatoriums which had 17,047 beds. Approximately 105,000 people were believed to need medical care; therefore it was difficult to cope with that situation with the number of beds.

In reality, in 1989 there were 37,698 inpatients for the 10,803 beds: 5,942 in national hospitals, 4,041 in public hospitals, 19,584 in corporate hospitals, and 8,131 in private mental clinics (hospitals). The total number of mental out-patients was 1,904,703 persons: 235,378 persons in national hospitals, 209,915 persons in public hospitals, 991,209 persons in corporation hospitals and 462,201 persons in private clinics (see Table. 7.6).

Table 7.6. Activities of Hospitals with Mental Health Services, 1989

| | No. of Beds | Inpatients (Person) | | Daily Average of Inpatients (Person) | Average Length of Stay (Day) | Outpatient (Person) | | Bed Utilisation Rate (%) |
|-------------|-------------|---------------------|-----------------|--------------------------------------|------------------------------|---------------------|--------------|--------------------------|
| | | No. of Inpatients | No. Of Bed-days | | | No. Of Outpatients | Average /Day | |
| Mental | 10,803 | 37,698 | 3,541,139 | 9,702 | 94 | 1,904,703 | 5,218 | 89.8 |
| National | 2,246 | 5,942 | 581,462 | 1,593 | 98 | 235,378 | 645 | 70.9 |
| Public | 731 | 4,041 | 242,564 | 665 | 60 | 209,915 | 575 | 91.0 |
| Corporation | 4,599 | 19,584 | 2,088,221 | 5,721 | 107 | 997,209 | 2,732 | 124.4 |
| Private | 3,227 | 8,131 | 628,892 | 1,723 | 77 | 462,201 | 1,266 | 53.4 |

Source: MoHSA (1990) *Yearbook of Health and Social Statistics*, Seoul, Korea, MoHSA.

However, most mental hospitals were usually centralised and not easily accessible, so people often sought help from them only as a last resort. The hospitals were large in

size, and built for economy of function rather than treatment. In a way, the private mental sanatorium (asylum) became a community of its own with very little contact with society at large. Furthermore, Korea did not have adequate training programmes at a national level to train psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers and occupational therapists. Since there were few specialised professionals, the community turned to the available traditional healers.

As a result of these various factors, there was a negative institutional image of people with mental health problems, which added to the stigma of suffering from mental health problems. These institutions were not in step with developments concerning the human rights of people with mental health problems. People with mental health problems were involved in labour activities under conditions of slavish subordination. Sexual rights and communication rights were not generally restricted, but limitations and restrictions were imposed in order for them to receive treatment under a restricted environment based on protection.

The slow spread of health insurance cover to the whole population seems to have led, in Korea, to an increasing number of patients being treated in psychiatric hospitals. The number of psychiatric in-patients increased from 14,456 in 1984 to 45,194 in 1997 (MoHW, 1998). Most of these (about 80 per cent) are 'admissions by relative', the equivalent to the caretaker system, with voluntary and emergency admissions running at about 10 per cent each. Groups of mentally disabled patients were 'accommodated in concentration camps not treatment organisations', 10,000 people with mental health problems were detained in camps for juvenile vagrants and were receiving 'maltreatment rather than humanistic treatment for care' and 18,000 people with mental

health problems, accommodated forty to fifty to a room without access to a doctor, 'enduring animal like living conditions with cruel violence and surveillance' (Kim, C. B. 1993, p.184).

Not until the early 1980s did the Korean government appoint an expert commission to investigate both the living and treatment conditions of people with mental health problems. After the broadcast of the TV series '*Chujuk 60 Bun*' which revealed the poor condition within private mental sanatoriums, the government sought to prepare a plan aimed at providing services including prevention and treatment of mental health problems and social integration programmes. To this end, the government established a plan for managing those with mental health problems from 1984 to 1991. This plan influenced by government policy aimed at activating a welfare society (Oh, 1997).

7.3.2. Policy Developments during the 1990s

During the 1990s the definition of mental health policy can be broadly interpreted as including a concern for treatment and rehabilitation and having the characteristic of isolation in mental health facilities. First of all, the policy for treatment and rehabilitation in the 1990s called for implementation of a plan that increased the number of national mental hospital from three (1991) to six and increased the number of doctors and beds to fifty-eight doctors and 1,950 beds in 1993. Also, the Korean government implemented a policy to increase the number of public mental hospitals in the city and provincial areas from eight to fifteen in 1993, and to increase the number of doctors to more than forty-eight and the number of beds to more than 1,785 in 1993. The Korean

government supported seventy-seven mental sanatoriums that were being turned into formal medical facilities. This policy intent can be seen in article 6 and 10 of the Mental Health Act, which allows a person who receives a license for the establishment of corporate mental health care to establish and operate mental sanatoriums (Dong-A Ilbo, 1990).

Secondly, Korean mental health policy during the 1990s has the characteristic of isolation in mental health facilities. The Korean government and ruling party prepared a bill and tried to enact it in article 21 concerning legal hospitalisation. These articles were opposed by Korean human rights organisations and mental health science organisations. The articles were heard in a public hearing. The proposed legal hospitalisation article provides that in cases where someone who can be acknowledged as harmful to self or others rejects hospitalisation and for whom an agreement from a guardian can not be received, a governor or city mayor, after receiving the diagnosis of two psychiatric specialists, can ask for mental health care facility protection and treatment. The emergency hospitalisation article prescribes that in cases where someone is highly likely to injure themselves or others and the situation is very urgent, after being seen by medical doctors and policemen, he or she can be hospitalised in an emergency.

In addition, the younger members of the Korean Association for Neuropsychology, the Medical Doctors' Association for the Practice of Humanism, and human rights organisations were against these changes, especially the members of the Medical Doctors' Association for the Practice of Humanism. Dr. Byunghoo Kim of Chongno, a neuropsychologist in Seoul, questioned whether any legislative members had been in

the mental sanatoriums that they intend to acknowledge as medical psychiatric facilities. He opposed the legislative intention of the government, arguing that a mental sanatorium accommodates forty to fifty patients without even one doctor and that patients admitted suffer from violence, surveillance, and animal-like living conditions, like a prison (Dong-A Illbo, 1990).

However, the Ministry of Health and Social Affairs, which was a major agency in the Korean government, attempted to implement a policy to increase medical facilities related to mental health. Also, the government and ruling party tried to promote the legalisation of the use of mental health facilities by enlarging the function of treatment, rehabilitation, and isolation.

Finally, the mental health services implemented during the 1990s by the Korean government tended to fail to secure enough financial resources so that mental patients could be treated to return to society as normal persons. More mental hospitals were expected to be established and the number of doctors and their working conditions was expected to be improved even though the number of beds was increased, as the budget of the Korean government increased from \$32.9 billion (24 trillion 666.9 billion Won) in 1991.

7.3.3. Mental Health Research Projects funded by the Central Government

In 1994 the Ministry of Health and Welfare began to call for some research projects on the development of mental health care services. These are: 'Aju' University's research

on 'on-the-spot survey of inpatients and inmates with mental health problems and a guideline of reclassification of them'; the Korean Institute of Health and Social Affairs' on-the-spot-survey of mental health facilities and mental sanatoriums; Seoul National University's research on the policy proposal on mental health. The result of these projects produced some significant suggestions. These were: an overview of the present condition of mental health care services; the actual condition of long-term inpatients within hospitals and long-term inmates within sanatorium; the problem of inadequate admission procedures; the necessity for the development and proliferation of rehabilitation therapy and community placement and settle-down programmes; the requirements of introducing community mental health care (Ministry of Health and Welfare, 1994; Seoul National University, 1995; Korean Institute of Health and Social Affairs, 1994).

'Seodaemun-Ku' Welfare Centre in Seoul developed a model which was able to manage people with mental health problems who are cared for in their own homes in the community. 'Sarangpat' Rehabilitation Centre (formerly mental sanatorium) which is located in 'Kyonggi' Province offered a project on the development of community placement programmes model for long-term inpatients to 'Aju' University. This project, however, had limitations in continuing to spread out to the other mental health facilities due to funding difficulties.

7.3.4. Formulating a Mental Health Act

The government of Korea formulated a mental health law. The law included major substantive and procedural changes to the mental health regime criticised at home and abroad as systematically incapable of protecting the human rights of hospitalised mental patients. The act was Korea's first legislative initiative expressively concerned with the protection of mental patients' rights and an institutional shift away from inpatient confinement and treatment toward community-based social rehabilitation of people with mental health problems.

It envisioned fundamental changes in the legal regime and institutional environment regarded by many as shaped unduly by public safety concerns to the exclusion of therapeutic rehabilitative goals. It was more likely to be an urgent task to draft a bill with broader perspectives for an ideal law in line with government policies for social welfare being carried out actively. The World Health Organisation (WHO) attempted to put forth a series of reference materials for countries which need either to legislate or revise their mental health laws. Like many developing countries, after entering a phase of industrialisation and economic growth, Korea has paid attention to learning a great deal from the experience of other countries and utilising this knowledge in establishing an efficient public mental health system and formulating an ideal law sympathetic to encompassing its unique values and cultural tradition, while keeping pace with modern techniques for the prevention and cure of mental illness. In this respect Korea attempted to follow the legislative guidance contained in the WHO publication entitled *The Law & Mental Health: Harmonising Objectives* (WHO, 1970). This guidance suggested ten items to be considered prior to formulating a new law or amending an existing one.

They were (a) policy and objectives; (b) authority; (c) budget; (d) operations; (e) research and training; (f) access to services; (g) protection of individuals; (h) minimum standards for mental health manpower and resource; (i) regulation of therapeutic medicines and other treatment methods; and (j) delegation of regulatory powers.

Furthermore Korea considered adding some points which were important to take account the unique circumstances of Korea, and avoid copying the laws of other countries. Other crucial points to consider in the formulation of a law were the attitudes and knowledge about mental illness of the general public and government officials, educating them about mental illness, the nation's unique value system based on its traditional culture, and the psychiatric healing methods and ideas of the past.

The Korean Constitution 10 expounds human dignity and values and the protection of fundamental human rights. Mentally disordered offenders can not be punished by reason of criminal incapacity in Criminal Code 10, and are to be hospitalised under the Social Protection Act enacted in December 1980. Furthermore, the mental health act was enacted in order to take measures to protect people with mental health problems and persons dangerous to themselves or others.

In 1968, the Korean Neuropsychiatric Association attempted to harness public opinion for the enactment of the Mental Health Act. The Korean Government had some difficulties in establishing the Act. In 1985 and 1990, the Ministry of Health and Social Affairs put forward proposal for the Act twice. That proposal was far from the ideal form which has been suggested by the Korean Neuropsychiatric Association; in particular, the issues of involuntary commitment procedures and systems and standards

of the mental health facility of the government proposal was too controversial to be accepted.

As mentioned, involuntary hospitalisation was very controversial in the government proposal of the Mental Health Act. The Korean Neuropsychiatric Association suggested some essential components of involuntary commitment procedures (Kim, E. Y., 1991).

These were:

- (a) Two physicians' (mainly psychiatrists) agreement or the agreement of one physician and one approved mental health professional for long term involuntary hospitalisation of mental patients;
- (b) At least one physician's agreement for short term involuntary commitment for evaluation even in emergency situations;
- (c) Agreement of mental health personnel or a security officer for the involuntary commitment of extremely dangerous mental patients in the case of an emergency situation impossible to get agreement from a physician;
- (d) The patients who are involuntarily committed should have the right to treatment and the right to refuse treatment.

There were some issues and regulation that the Mental Health Act must contain (Kim, E. Y., 1992).

- (a) Regulation of staffing ratio of mental institute, statement of qualification of mental health professional;
- (b) Regulation to protect patient's privacy and to prohibit unnecessary physical restraint and isolation of patient;
- (c) Regulation to promote adequate treatment;
- (d) Issues and regulation concerned with local mental health tribunal and its activity.

Passed by the National Assembly in December 1995, the Mental Health Act included a number of significant features:

- (a) Defined the hospitalisation procedure (voluntary admission, admission by consent of family members, emergency admission, admission for assessment, admission by a guardian);
 - (b) Defined the rights of people with mental health problems and limited restriction of patients' rights in hospital;
 - (c) Defined the qualifications of mental health workers (mental health nurse, mental health psychologist, mental health social worker);
 - (d) Defined the minimum qualifications for mental hospital, psychiatric long-term hospital, psychiatric clinic in terms of man-power, facilities;
 - (e) Promoted the mental health service in Health Centres;
 - (f) Defined the characteristics and qualifications of new mental health facilities (psychiatric long-term hospital and community rehabilitation centre).
- (Ministry of Health and Welfare, 1999)

7.3.5. Implementation of Mental Health Act 1995

In 1996 the debate on the enforcement ordinance and enforcement regulations of the Mental Health Act 1995 was a hot potato. A great number of different views from professional groups surrounded the implementation of the Act. The controversies over this were: the qualifications of mental health professional manpower; the requirement of training courses and a qualifying examination; and the roles and responsibilities of mental health professionals.

In 1996, there was a considerable debate on establishing social rehabilitation facilities, especially the size and type of facility, the main body of management and the methods of funding system. The debate was more likely to have been confused because there was no experience of operating this kind of facility. The Mental Health Act 1995 does not embrace the basis for the establishment of community mental health centres, regulation

for establishing and operating workshop facilities and home visiting and case management services and community education and support. This was due to a lack of understanding about the concept of community mental health care. In Korea themes of mental health, such as human rights of those with mental health mental health problems, social integration, rehabilitation, and improving quality of life, which had been ignored for a long time were discussed substantively and reached a stage of implementation through the enactment of the Mental Health Act 1995 and the Community Health Act 1995 (Suh, 1999).

However, in the aftermath of the Mental Health Act 1995, the Korean government attempted to play an active role in defining problems and setting goals in the mental health area. Policy makers did not wait for the system to work; they directed its operations by establishing problem-defining and priority-setting mechanisms within government. Prior to the Mental Health Act 1995, decision makers seemed prefer to await pressure to act to the more proactive role of encouraging pressure from certain groups (essentially providing support for the process) and actually monitoring events so as to determine results and judge where action was needed. The government attempted to play an active role in the development of a mental health policy:

Formulating mental health legislation; establishing comprehensive mental health policy; expanding mental health facilities and mental health workers (mental health infrastructure); reconsidering the socio-psycho-medical model; rethinking the policy direction for community-based mental health service provision; allocating the budget for mental health research, policy development and pilot projects; establishing the system for management of mental health problems; improving the quality of care in mental health facilities especially mental sanatorium.

(Ministry of Health and Welfare, 1997a).

The Korean government was aware of the problem of basing a mental health policy solely on traditional hospital-based psychiatry.

The definition of mental health policy can be broadly interpreted as including a concern for treatment and rehabilitation and having the characteristic of isolation in mental health facilities.

(Ministry of Health and Welfare, 1997b).

In February 1997, there was a meeting on the formation of a Central Mental Health Commission – the Deputy Minister of Ministry of Health and Welfare was in the Chair - which represented mental health professionals - psychiatrists, nurses, psychologists and social workers and consumer groups. This committee dealt with long-term and short-term mental health policies aimed at reinforcing rehabilitation and treatment for those with mental health problems for the first time since the Mental Health Act 1995.

The Ministry of Health and Welfare (1997) held the 1st Central Mental Health Commission which dealt with short-term and long-term mental health policies: They established policy direction on mental health care:

- (a) To expand public mental hospitals;
- (b) To reinforce function of rehabilitation and treatment;
- (c) To establish and support social rehabilitation centres;
- (d) To shift mental nursing facilities to mental hospitals.

(MoHW, 1997)

To expand state mental hospitals and reinforce the function of rehabilitation and treatment, the plan was aimed at establishing two new state-sponsored mental hospitals and establishing occupational rehabilitation centres in the existing state mental hospitals

in order to shift mental health services from hospital care to social rehabilitation and treatment. To this end, training facilities and equipment and staff would be increased. To establish and support social rehabilitation facilities, up to 2003, Social Rehabilitation facilities provided social skills training and occupation training so that those with mental health problems were enabled to adapt to daily living in the community. To encourage non-government organisations (voluntary organisations) to take part in providing mental health services and programmes, the government would provide some subsidies and grants. To reinforce treatment throughout the shift from mental nursing facilities to mental hospitals, the 78 existing mental nursing facilities would be converted to mental health hospitals in order to reinforce the function of treatment. The government would support 1,000 million won (0.5 million GBP) per mental nursing facility to convert their function.

Short-term policy direction was aimed at protecting the individual human rights of those with mental health problems and reinforcing the function of state mental hospitals. Mid and long term policy direction aimed at expanding mental health facilities providing appropriate treatment and rehabilitation services and programmes and establishing and supporting social rehabilitation centres.

In addition, a system of Mental Health Review Tribunals was created to review all involuntary admissions and to hear appeals from patients about their release or improvement of treatment. They also raised some agendas on human rights for those with mental health problems. People with mental health problems were segregated from their own home and community. There was a consensus on mental health services toward community-based care in order to protect individual human rights and increase

quality of life.

7.4. Characteristics of Mental Health Policy before the Economic Crisis

The evolution of mental health policy in Korea until the 1990s has been examined. Since the Mental Health Act 1995 was passed the government has established some measures to promote mental health care programmes and services for mental health patients, particularly those who were discharged from mental hospital. The division of Mental Health was established in the Ministry of Health and Welfare in 1997. It is an interesting point that the state role in the provision of social welfare as a regulator was intact during this period.

7.4.1. Mental Health Policy Making under the Economic Growth Strategy

The developmental experience of Korea in the 1970s, in particular 1973 when the Heavy and Chemistry Industrialisation Plan was being launched, should be a model of the developmental state. Compared to the active role of the state in the economy, however, the developmental state in Korea played only a small role in social welfare. The welfare system was a residual system (Shin, 2000b). The National Pension Programme was put off for an indefinite period in spite of the legislation of 1973. The Medical Insurance Programme was partially introduced only for workers working in large firms. The state hardly committed to increasing its burden for social welfare. Thus during the 1970s, economic development was carried out with little degree of social

welfare. There is no doubt that the predominance of economic development driven by the HCI in the policy making process significantly influenced the form and content of social policy in the 1970s. It is clear that social policy was significantly constrained by economic policy, though the content and form of social policy was established by the political elites. In these circumstances, up to the 1990s the national mental health system was not established in Korea because those with mental health problems were supported by families and communities. In this respect government has long neglected its role in the development of a mental health care system. Also, relatively small problems and pressures on mental health policy making, such as a proportionately lower population of people with mental health problems and comparatively active informal welfare practices seem to be the main factors enabling the government to legitimate a lower standard of mental health services.

It is an interesting point that there was a series of legislation concerning social security in the early 1960s. However, only a few programmes, including the Industrial Accident Compensation Insurance (IACI) and the Occupational Pension Scheme for government employees and military personnel together with pilot medical insurance programmes, which could not be denied as being a social security system in a strict sense, came into effect in the 1960s. Social security expenditure was inevitably very low, remaining at around one per cent of the GDP (see Table 7.7). Thus, Korea witnessed the establishment of a preferential welfare system to provide special treatment only for very limited groups whose support might be crucial for the survival of the regime. It was clear that social policy including mental health policy during the 1960s was greatly constrained by the requirements of export-oriented industrialisation.

Table.7.7. Medical Expenditure on Psychiatric Service in Korea

(unit: million won)

| | Type of service | 1992 | | | 1996 | | |
|-------------------|-----------------|-------------------------------|-------------------------|---------|-------------------------------|-------------------------|---------|
| | | Total Medical Expenditure (A) | Psychiatric Service (B) | B/A (%) | Total Medical Expenditure (A) | Psychiatric Service (B) | B/A (%) |
| Total | Inpatient | 1,525,138 | 90,557 | 5.9 | 2,968,749 | 181,440 | 6.1 |
| | Outpatient | 2,479,880 | 64,732 | 2.6 | 4,991,011 | 113,906 | 2.3 |
| | Total | 4,005,018 | 155,732 | 3.9 | 7,960,731 | 295,346 | 3.7 |
| Medical Insurance | Inpatient | 1,376,498 | 47,013 | 3.4 | 2,690,731 | 85,593 | 3.2 |
| | Outpatient | 2,327,486 | 56,296 | 2.4 | 4,732,984 | 101,373 | 2.1 |
| | Total | 3,703,984 | 103,309 | 2.8 | 7,423,716 | 186,966 | 2.5 |
| Medicaid | Inpatient | 148,640 | 43,544 | 29.3 | 278,018 | 95,847 | 34.5 |
| | Outpatient | 152,394 | 8,436 | 5.5 | 258,277 | 12,533 | 4.9 |
| | Total | 301,034 | 51,980 | 17.3 | 536,295 | 108,380 | 20.2 |

Source : MoHW (1997) *White Paper of Health and Welfare*, Seoul, Korea, MoHW.

The extension of the National Pension Programme (NPP) to farmers and fisherman and the introduction of the Employment Insurance Programme (EIP) took place during the Kim Young Sam government (1993-1997). However, the government continually played the role of a regulator rather than a provider of welfare provision. In particular, welfare reforms in the Kim Young Sam government seem to be towards more limited income security programmes. They included tightening conditions of access to unemployment benefit, putting more emphasis on active measures, introducing a private pension scheme, adopting a market-conforming approach in pension and cutbacks in pensions. At the same time, the government increasingly emphasised the responsibility of the family and the role of the private sector in welfare provision. It is argued that the social policy in the Kim Young Sam government was transformed towards 'a business friendly one' (Shin 2000b, p.246). In this context, mental health policy was still a low priority until the 1990s although Korea had been under a great deal of internal and external criticism for its mental health system being overwhelmingly hospital based while other advanced industrial countries in Western Europe and North America had

experienced a policy shift from institution to community care for those with mental health problems.

7.4.2. Who's to Care? State, Market, or Family?

People with mental health problems were cared for by their families and communities rather than by the state. Prior to the 1970s, familial care (kinship obligation) was a crucial resource in caring for those with mental health problems and the state stood back from service provision. In other words, there was an emphasis on familial responsibility rather than on the responsibility of the state to ensure the wellbeing of its citizens before the 1970s. Family care was seen to be the preferred option for the provision of care to 'needy' individuals. If family care was unavailable or insufficient, then people should have the option to choose to purchase care from a private supplier, or to receive support from voluntary agencies, rather than automatically assume that services would be provided directly by the state.

In the family system in Korea the head of a family (i.e., the father) possessed exclusive authority and ownership of property and the eldest son inherited this privilege. The head of the family was also obliged to take care of family members and administer their activities. The family was then understood to be a 'co-operator' to limit any increase in public welfare expenditure, and it came to be regarded as the main source of welfare provision. There is little doubt as to the importance of families in the overall Korean welfare mix. Public social services, be it to the aged, children or people with mental

health problems, are truly marginal because it is institutionally assumed that the family must carry the real responsibility.

Given that home confinement was no longer an option, hospitalisation had several advantages. First, it preserved the primary mental health policy goal of social order by indefinitely confining individuals, much like home confinement did. Secondly, by adopting a policy that encouraged the building of private psychiatric hospitals, the government distanced itself from a primary social welfare role vis-à-vis people with mental health problems and their families. Third, although hospitalisation was not as good as home confinement in preserving family responsibility for family members, hospitalisation in private psychiatric hospitals did preserve many of the features of family responsibility (i.e. the family paid).

Related to other dependent populations, older people benefited more than others as Korea switched from a focus on economic growth to a more balanced growth. In that same vein, people with mental health problems perhaps benefited the least. Part of the explanation was certainly the relationship of social welfare and economic policy to populations and sectors directly affected by economic policy which benefited the most from the development of a social welfare policy. There was an implicit obligation towards those who created the rapid economic growth, and are now the elderly. Additionally, urban and economic growth patterns broke down the tradition of the eldest son's family caring for ageing parents. The wives of the eldest sons, on whom this responsibility fell, are often working now themselves or are otherwise unable or unwilling to assume this role.

Social welfare policy towards families and children also benefited, largely driven by economic concerns. Educational policy was highly vocational and related to the needs of industry. Other family benefits were similarly tied to economic issues. Family-allowance benefits encourage families to have children, a concern as Korea experiences a declining birth rate and a declining work force.

In contrast, people with mental health problems had almost no role in the Korean economy except as a commodified group for the psychiatric hospitals. As individuals and as a group, they were not needed in the economy. 'Capitalism needed skilled workers and therefore the state intervened to provide an educated and healthy workforce. To maintain legitimacy, the state provided transfer payments for the unemployed and the elderly. Infrastructure expenditure on hospitals, roads, and housing could be described as contributing to the accumulation process' (Mullard and Spicker, 1998, p.45).

Although the government has been active in developing progressive social welfare policies for much of the populations, this has been pursued most aggressively as it benefits or is an outcome of the economy. People with mental health problems do not fit into that equation in any obvious way. To that extent, they have remained beyond the concern of policy development. While there have been consistent internal critics of Korean mental health policy at least since 1980s, the government was notably unresponsive to them until the early 1990s.

7.4.3. The Lack of Mental Health Facilities and Staff

In order to cope with mental health problems, psychiatrists and mental health-related workers are expected to work in the front lines of mental health. Thus, in a way, the number of psychiatrists available in a society may serve as some kind of index of the nature of the mental health system functioning in the society. The figures available for Korea between 1965 and 1995 reveal that the number of psychiatrists per 100,000 population was much lower than in some western societies, particularly the United States (see Table 7.8), where the number of psychiatrists was 8.9 per 100,000 population in 1990. Korea had the much lower number of 3.9 in 1990.

Table 7.8. The Number of Psychiatrists Per 100,000 Population

| | 1965 | 1970 | 1975 | 1980 | 1985 | 1990 | 1995 |
|-------|------|------|------|------|------|------|------|
| Korea | 0.4 | 0.8 | 1.2 | 1.2 | 1.6 | 2.4 | 3.9 |
| USA | - | - | 5.6 | 7.0 | 7.8 | 8.0 | 8.9 |

Source:

- 1) MoHW, *Annual Statistics of Health and Welfare*, Seoul, Korea, MoHW, *Various Years*..
- 2) Department of Health & Human Service (1997) *Health United States, 1996-97 and Injury chartbook* Hyattsville, MD, Department of Health & Human Service.

The above table regarding the number of psychiatrists available in the two societies needs thoughtful interpretation. Several issues need to be considered, such as the major function of psychiatrists in their clinical work. In many societies, psychiatrists are primarily involved in the delivery of care to severe psychiatric patients, mainly in inpatient settings, and less involved in mental health-related work, such as psychological counselling for those with less severe mental health problems in a population or mental health education and preventive work for the normal population.

The geographic distribution of the availability of psychiatrists within a society also needs to be considered. Like many developed societies, there is a heavy concentration of psychiatrists in urban settings and severe shortage in rural areas, even though the total number of psychiatrist is relatively high. As Table 7.9 shows, another index conventionally used to reflect the quality of psychiatric service is the number of beds available per 10,000 of the population in Korea.

Table 7.9. The Number of Psychiatric Beds Per 10,000 Population

| | 1980 | 1983 | 1990 | 1994 |
|---------------------|------|------|------|------|
| Korea ¹⁾ | - | 1.7 | 2.9 | 2.9 |
| USA ²⁾ | 12.4 | 11.3 | 11.2 | 10.7 |

Source:

- 1) WHO (1995) *Report of the Fifth Co-ordinating Group Meeting on Mental Health Programme*, Office for the Western Pacific : Manila, WHO.
- 2) Department of Health & Human Service (1997) *Health United States, 1996-97 and Injury chartbook* Hyattsville, MD, Department of Health & Human Service.

7.4.4. The Poor Quality of Mental Health Services

One needs to be careful not to simply consider a greater number of psychiatric beds as being equal to better mental health services. The number merely indicates quantity and does not reflect quality of services. However, it does reflect, to some extent, the amount of psychiatric service available to the population, particularly for severely ill patients. Closely related to the number of psychiatric beds available in a society is how the psychiatric beds are utilised. For instance, are the beds used for acute care or for custodial care? This indicates the nature of the psychiatric system and the services that are offered in a society.

From a public health point of view, one should ask about the distribution and availability of service systems in the society as a whole. It can be problematic if the quality of available psychiatric service is very uneven. Actually, this is a serious problem still observed in many parts of the world, including Korea. There was an urgent need for societies to develop mental health service networks that extend into the community rather than remain contained in institutions in large urban settings. There is also a great need to expand the function of psychiatrists from caring for severe mental patients to patients with minor psychiatric or mental health work. In Korea at present, psychiatrists concentrate heavily on the biological treatment of severe patients in inpatient settings, and almost neglect the psychological care of the large number of patients with minor disorders in outpatients settings, who are in great need of service. In other words, there is a need to expand psychiatric work to mental health work.

There is a need for the development and implementation of programmes whose goal is to normalise the lives of persons with mental health problems and integrate them as fully as possible into community life. The recent growth of the consumer and family advocacy movements has also served to increase the social visibility and political clout of people with mental health problems. In addition, an increased recognition in many nations of the need to better safeguard the human rights of people with mental health problems leads one to hope that perhaps a better future is possible for those suffering from serious, long-term mental health problems.

There were some problems with hospitalisation under the Mental Health Act 1995. The Act created no provisions for community-based services. Screening services were a function of the hospitals themselves. Discharge was rare and, when it occurred, post-

hospitalisation care was a family responsibility, thus obviating the need for formal aftercare services. Prevention services were also a missing feature of the act.

7.4.5. Social Control rather than Care and Treatment

Mental hospitals began to become more numerous in the 1980s and 1990s (see Table 7.10), a time when Korea's increased industrialisation led to greater urbanisation and increased population mobility. These social trends meant that families were less able to care for, or provide home confinement for, mentally ill family members and preferred to pay for their care through external agencies instead.

Table 7.10. Trends of Psychiatric beds in Korea

(unit: beds, %)

| | | '84 | '87 | '90 | '93 | '96 | '97 |
|-----------------------------|-----------------------|--------|--------|--------|--------|--------|--------|
| Mental Hospital | National/ | 1,930 | 2,663 | 3,708 | 4,284 | 5,570 | 5,779 |
| | Public | (100) | (137) | (192) | (221) | (289) | (299) |
| | Private | 1,022 | 2,542 | 4,964 | 5,763 | 9,360 | 11,255 |
| | | (100) | (248) | (485) | (563) | (916) | (1101) |
| | Subtotal | 2,952 | 5,205 | 8,672 | 10,047 | 14,930 | 17,034 |
| | | (100) | (176) | (293) | (340) | (506) | (577) |
| General Hospital & Hospital | General H. & Hospital | 2,064 | 3,371 | 4,219 | 5,488 | 7,754 | 7,608 |
| | & Hospital | (100) | (163) | (204) | (265) | (376) | (369) |
| | Psychiatric clinic | 1,091 | 999 | 1,218 | 1,384 | 1,492 | 1,644 |
| | | (100) | (91) | (111) | (126) | (137) | (151) |
| | Subtotal | 3,155 | 4,370 | 5,437 | 6,872 | 9,246 | 9,252 |
| | | (100) | (138) | (172) | (217) | (293) | (293) |
| Subtotal | | 6,107 | 9,575 | 14,109 | 16,919 | 24,176 | 26,286 |
| | | (100) | (156) | (231) | (277) | (396) | (430) |
| Psychiatric asylum | | 8,349 | 12,538 | 17,432 | 17,696 | 18,182 | 18,908 |
| | | (100) | (150) | (208) | (211) | (218) | (226) |
| Total | | 14,456 | 22,113 | 31,541 | 34,615 | 42,358 | 45,194 |
| | | (100) | (152) | (218) | (239) | (293) | (313) |
| Total population (1,000) | | 40,406 | 41,575 | 42,869 | 44,056 | 45,248 | 45,991 |
| | | (100) | (103) | (106) | (109) | (112) | (114) |

Source: MoHW (1998) *Yearbook of Health and Welfare Statistics*, Seoul, Korea, MoHW.

Hence, moral hospitalisation became the main approach to treatment. However, this was not the goal of policy towards those with mental health problems before industrialisation, and this did not appear to be the goal of policy during the industrialisation period. Rather, social control remained the consistent goal.

Thus, in these three areas, minimising state financial involvement, retaining family responsibility for family members and social control, hospitals would have had to provide benefits over home confinement. There was no impetus to change the traditional policies and practice towards people with mental health problems. Home confinement fulfilled the function of maintaining social control, and the official but unimplemented policy of hospitalisation fulfilled the need to appear modern while also meeting changing family situations. Korea was still peripheral enough as a nation, and mental health policy was marginal enough as social policy.

The overall concern of mental health policy was its need to change from the maintenance of social order to something else - treatment or rehabilitation, for example. However, there were several problems militating against this, Korea retained a very strong social stigma towards mental illness, people with mental health problems, and families with mentally ill members. This excluded the mentally ill from being considered a part of the social group. Consequently, their reintegration into the wider society became problematic. The problem was whether to reintegrate them and on what basis?

7.5. Summary

This chapter has explored the government's policy responses to perceived social problems related to mental health prior to the economic crisis of 1997. During the industrialisation period, people with mental health problems tended to be treated with contempt and to be left alone in Korean society. Recent value changes have tended to weaken the consciousness of family care for those with mental health problems. While there were rare cases of people with mental health problems in the earlier agrarian society, the prevalence of mental health problems has increased because of the population increase, urbanisation, industrialisation, the conflict of feudalism and the free economy, and the seriousness of social conflict. Also medical facilities and the number of doctors and beds has been increasing. Private organisations have established mental sanatoriums, accommodating mental patients, and are receiving governmental benefits.

However, there was low priority for mental health care until the 1980s in Korea. People with mental health problems were cared for by their families and communities rather than by the state or other services. Since the 1980s there have been remarkable advances in the understanding of and response to mental health problems from both the state and the public. There has also been a great recognition of the need to promote mental health service provision.

An overriding feature of the Korean mental health system prior to the economic crisis of 1997 is its concern for maintaining social order and the perception that those with mental health problems somehow contribute to a threatening of the social order.

Although there are private psychiatric hospitals, their fees for treatment (both in-patient and out-patient) are covered by national health insurance schemes. Therefore, private hospitals are rather keen to keep as many patients as possible as long as possible for financial reasons. This system has resulted in a very long average length of stay for mental patients in Korea.

Despite the forces of industrialisation and urbanisation, most Korean families were encouraged to keep the traditional values of caring for their mentally ill family members, and the family continued to be the basis of the care of those with mental health problems. This assumption is shared by policy makers who believe that the sense of family responsibility for the care of those with mental health problems should be encouraged and activated by policy intervention.

Chapter 8. Reconstructing Mental Health Policy after the Economic Crisis of 1997

The previous chapter examined the development of mental health policy during industrialisation. Through the analysis of mental health policy prior to the economic crisis of 1997, the changing role of the state in providing mental health care services for those with mental health problems has been found. Along with the expansion of the welfare policy programme, Korean mental health policy and practice was developed. To respond to mental health problems, the Korean government established a mental health policy and formulated mental health legislation to provide those with mental health problems with mental health care services. Also the government aimed to overcome the disparity between the needs of people with mental health problems and the available services.

However, Korea was under a great deal of criticism from at home and abroad for being out of step with the rest of the industrialised world on basic issues of individual human rights. There was also a great deal of internal and external criticism for its mental health system being overwhelmingly institutionally based while other advanced industrialised countries had moved to community-based services. To respond to these criticisms the Korean government attempted to establish a mental health policy and to formulate a Mental Health Act. The policy and legislation was expected to protect some individual human rights, and it allowed for the creation of some community-based programme models that had always existed in Korea, but which were not officially authorised.

Following the enactment of the Mental Health Act 1995, the role of government was strengthened in the mental health policy arena.

However, from the end of 1997, the Korean GDP was halved (in dollars terms) and the country was on the brink of bankruptcy. Although the Korean government managed to avoid a financial moratorium with the help of the International Monetary Fund, the financial crisis began to take its toll. For instance there was a massive increase in unemployment. The Korean welfare state also began to feel severe strain due to this economic and social crisis. In the wake of the economic crisis of 1997, the Korean government had to manage a financial moratorium with the help of the IMF. In such a circumstance, Korean welfare programmes including mental health care were constrained by spending considerations. In this respect, it might be that spending consideration influenced the mental health policy and practice.

The thrust of this chapter is on policy responses to perceived social problems related to mental health (i.e. the increasing number of people with mental health problems) along with the inauguration of a relatively progressive government in Korea in the aftermath of the economic crisis. The question this chapter seeks to answer is whether the role of the state within the welfare system was changed in the area of mental health policy.

This chapter is divided into four sections including the summary, the first section examines the relationship between the social changes and mental health in the aftermath of the crisis. Section two tries to explore the reconstructed mental health policy under the productive welfare approach. In section three, the basic features of mental health policy and practice after the economic crisis are identified.

8.1. Economic Crisis and Growing Demands for Mental Health Care

This section begins by describing those socio-demographic characteristics of Korea which are likely to have a significant impact on its population's needs for mental health services in the aftermath of the economic crisis. Second, the prevalence of various mental health problems in Korea has been directly measured in some recent studies, and this epidemiological work also provides valuable evidence on the likely extent of Koreans' mental health needs.

The evidence supporting this view comes from two major sources. First, several socio-demographic indicators have been found to have a marked influence on the prevalence of mental health problems and on mental health service utilisation. These include rates of unemployment and homelessness, and overall social deprivation.

8.1.1. Unemployment and Mental Health

It is said that large-scale layoffs by companies, international economic competition, computerisation and other factors, are associated with the increased prevalence of mental health problems. Tausing and his colleagues (1999) point out this:

Recent large-scale layoffs by companies known for the stability of their work force, international economic competition, computerisation, boring simple jobs, and other factors suggest that workers may be increasingly anxious about keeping jobs or about having enough money to get by, about supporting their family, and planning for the future (p.70).

With regard to the likely impact on needs for services in Korea in the aftermath of economic crisis, a series of studies has demonstrated that unemployment appears to have a considerable negative effect on mental health, with associations including depression, poor self esteem, anxiety, substance abuse and negative effects on relationships (Johoda, 1979; Frese and Mohr, 1987; Crawford et. al., 1987; Warr et. al., 1988; Bhugra, 1993).

Kammerling and O'Connor (1995) found unemployment to be the best predictor of admission rate, reporting a 0.94 correlation between these two variables. A study in north east London found that local rates of unemployment accounted for 81% of the variance in the rates of accumulation of new long stay patients in different health districts in the area (Thornicroft et. al., 1992). High level of unemployment and suicide rates has been found to correlate in several Western countries (Pritchard, 1992; Platt et. al., 1992). Thus this demographic characteristic again suggests the need for mental health services in Korea.

In Korea, during the economic crisis of 1997, large numbers became unemployed and unable to support dependants. An enduring image from that time is the man jumping from a building ledge to commit suicide after depression linked to his financial losses. Some unemployed men left their homes each day as though they were still working so as not to reveal to their neighbours that they had been laid off and in order to retain some sense of identity for themselves (Lee, E., 2002).

High unemployment rates may also have an impact on the types of services needed by people with ongoing mental health problems. Whilst they may be able to find jobs in

times of full employment, they are a group which is likely to be especially vulnerable to losing or not being able to find work when the country is in recession. A need for help with employment and with activity in general are thus likely to be currently at a high level among those with long-term mental health problems.

8.1.2. Homeless and Mental Health

The implications for population mental health needs of the homeless population are again considerable. There has been a study on mental health problems among homeless people after the economic crisis of 1997 (Kwoen, et. al., 1999). The main premise of the study was that mental health problems of the homeless tend to isolate them from society, prolong their period of homelessness and make it difficult for them to re-establish their well-being. Kwoen and his colleagues (1999) reviewed a number of mental health problems, a correlation was found among the mental health problems and changes in the problems with the lapse of time. They presented the major findings as follows:

- (a) Drinking problems of the homeless was much greater than normal persons
- (b) As for psychiatric symptoms, somatization, phobic anxiety and psychoticism were more serious than other symptoms
- (c) Drinking problem were positively related to somatization, phobic anxiety and psychoticism, so that homeless persons with drinking problem had more serious psychiatric symptoms
- (d) The period of homelessness was related to drinking problems, that is, the homeless who were living on a street-corner during a period of over 18 months had the most serious drinking problems
- (e) The period of homelessness was related to psychiatric symptoms, that is, homeless persons at an early stage and for a long period of time (over 18 months) had the most serious psychiatric symptoms (Kwoen, et. al 1999, p.47).

In this respect, there was also a growing demand for mental health care for homeless people at the early stages of homelessness in order to prevent them from prolonging their homeless period.

Conventional mental health services often fail to contact or engage the homeless mentally ill, so that specific services are needed. For example, clinics may be provided in places where the homeless tend to congregate or assertive outreach work is carried out on the streets. The needs of the homeless are particularly likely to be multiple, with many requiring interventions for physical health and psychological and social problems, so that there is a particularly important need for services which can provide a range of types of intervention and for good inter-agency co-ordination for this group.

8.1.3. Social Deprivation

The relationship between mental health problems and various measures of poverty, low social class or social deprivation became a major focus for psychiatric epidemiology in the first half of the twentieth century. Many positive findings have been reported since the original observation in the 1930s in Chicago where it was noted that there was a higher rate of admission for psychosis in poorer central areas than in more prosperous outer areas (Faris and Dunham, 1939). A series of subsequent studies have confirmed this tendency for people with mental health problems to be concentrated in inner cities (Eaton, 1985; Giggs and Cooper, 1987). The effects are particularly clear for schizophrenia, and there has been a debate over whether people born in the inner city

are at higher risk of psychotic illness ('social causation hypothesis'), or whether this finding is the result of mentally ill people tending to migrate to inner cities even if they are born elsewhere ('social drift hypothesis'). Recent research has tended to support the former view, that there is a true increased incidence of schizophrenia in individuals born or brought up in an urban environment (Castle et. al., 1993; Dauncey et. al., 1993). However, it is likely that 'social drift' operates as well, with the number of individuals with schizophrenia in the inner city inflated by migrants from more prosperous areas (Buszwicz and Phelan, 1994).

Despite Government measures, the sharp decline in incomes and the fact that most of the unemployment occurred among low paid temporary workers, meant poverty rose substantially. While estimates of poverty differ quite widely depending on whether consumption or income-based poverty estimates are used, all estimates show that poverty increased between two to three-times between the third quarter of 1997 and the third quarter of 1998, when poverty rates appear to have reached a peak. Estimates used by the Government (KIHASA), which are measured in terms of income, show an increase in poverty from 2.4 per cent in the third quarter of 1997 to 7.8 per cent in the third quarter of 1999.

World Bank estimates of the percentage of poor, measured by consumption expenditure, find that poverty rose from 8.5 per cent in the third quarter of 1997 to almost 24 per cent in the third quarter of 1998. Moreover, since the squared poverty gap index which measures the severity of poverty increased by more than the poverty gap index through the third quarter of 1998, the impact on the poorest was more severe.

The true impact of the crisis on poverty requires taking into account the trend reduction in poverty that would have occurred had the crisis not erupted. Since Korea had been successful in sustaining steady declines in the incidence of poverty throughout the 1990s, it is estimated that the crisis may have increased the incidence of poverty by over 128 per cent through the third quarter of 1998 (based on WB estimates measured by consumption expenditures). Although these trends had begun to reverse by the end of 1998, and the incidence of poverty declined to around 16 per cent (measured by consumption expenditures) or 7.4 per cent (based on income), this is still nearly double pre-crisis levels.

Thus population-level composite indicators of deprivation already suggest that mental health needs may be particularly great. A number of individual demographic characteristics are also good predictors of mental health needs and service use, in some cases appearing to predict variations in services use more powerfully than composite deprivation scores. Korea's position on the indicators most relevant to mental illness should be considered.

8.1.4. Increasing Number of People with Mental Health Problems

The epidemiological evidence on Korea's mental health needs in the aftermath of economic crisis is more likely to be direct, although not as comprehensive or as plentiful. As Table 8.1 demonstrates there has been the increased number of people with mental health problems after the economic crisis of 1997.

Table 8.1. Comparison of Mental Health Related Statistics between 1997 and 2002

| Classification | 1997 | 2002 |
|-------------------------------------------------|---------|-----------|
| Number of People with Mental Health Problems | 977,000 | 2,730,000 |

Source: MoHW (2003) *Health and Welfare Statistical Yearbook*, Seoul, Korea, MoHW.

According to a recent survey by the Ministry of Health and Welfare and the Psychiatry Department of Seoul National University's Medical School, based on interviewing 6,114 people over the age of 18 nation-wide, more than one in six (31.4 per cent) thought they had experienced a mental illness in their lifetime. By gender, male respondents (38.7 per cent) outnumbered female by 1.6 times. Among the so-called psychiatric conditions, addiction to alcohol recorded the largest with around one in six (16.3 per cent) having experienced it. The percentage is calculated assuming there are 22.6 million people over the age of 18. Men (25.8 per cent) far outnumbered women (6.6 per cent). Addiction to nicotine stood at 10.2 per cent or an estimated 2.1 million, of which men (18.5 per cent) also outnumbered women (1.6 per cent). Aside from addiction to alcohol and nicotine, the survey estimated 2.81 million adults need psychiatric care for depression of which women (19.4 per cent) outnumbered men (7.1 per cent). Emotional instability at 14.8% was the most reported disorder followed by panic attacks (9.1 per cent), worrying about one's health (1 per cent), psychopathic symptoms (1.1 per cent), and bulimia (0.13 per cent). During last year, an average 8.7 per cent of those surveyed, including those who were affected by alcohol (5 per cent), nicotine (4.4 per cent), depression (26.9 per cent), and anxiety (12.3 per cent) received medical care (Chosun Ilbo, 2002).

This section has explored a significant impact on its population's needs for mental health services in the aftermath of the economic crisis. In the following section, the government's policy responses to perceived social problems related to mental health in wake of the economic crisis will be examined.

8.2. Government's Response: Reconstructing Mental Health Policy

As explored in chapter 7, in Korea the deterioration of social conditions following the 1997 financial crisis has led to a rise in the demand for welfare services, while family ties and mutual co-operation in communities are declining. A new type of poverty has emerged among women, children, the disabled and the elderly without relatives, and within the urban areas. At the same time, income inequalities are widening, threatening a breakdown in social cohesion. In this circumstance, the Korean government has been expected to extend welfare provisions for people in need. However, the government also faced some obstacles to expanding welfare programmes. The obstacles were lack of funding and resources allocation. The government had to pursue economic recovery and stabilising strategies. The government policies therefore were highly driven by the economic situation.

In this respect, it is particularly important to identify how economic strategy constrained mental health policy decisions and the structure of mental health policy institutions. In addition, this chapter will look at the impact of this new direction of social policy on mental health policy making. As mentioned before, social policy has continued to be adapted to the economic situation. The government also attempted to pursue a strategy

of moderate development in mental health care provision.

Equally, it is very important to consider the cultural influences in the reconstruction of Korean mental health policy in the aftermath of economic crisis. As highlighted in Chapter 5 and 6, the Korean government considered the cultural factors before they formulated the policy since the 1960s. It is not surprising that the policy makers regarded the family as a major welfare resource. They also realised that Confucianism still plays an important role in shaping people's attitude to life in Korea. This has been institutionalised as an orthodox ideology since the Chosun dynasty (1392-1910). In this respect, it is important to examine how the Korean government reasserted social order to shape a new mental health policy towards community based service provision for people with mental health problems, particularly for those discharged from mental hospital and other institutions. Therefore, in this section, it is important to identify the ways in which the government reformulated the mental health policy and its system under the productive welfare approach.

8.2.1. The Policy Shift towards Community-based Mental Health Care

As noted in Chapter 3, mental health care over the last two centuries has been dominated by the rise and fall of the asylum in Western countries. Moving from institutional to community settings has triggered a whole new mental health enterprise called 'community care' or 'care in the community'.

In December 1995, the Mental Health Act was enacted and has been effective since

March 1, 1997, and this introduced the concept of public mental health. Since 2000 people with chronic mental disorders have been included in the criteria for people with disabilities who are entitled to receive social welfare services, such as economic support, employment and housing. Disability benefits for people with mental disability could reduce long-term institutionalisation and lead them to live more easily in the community.

To this end, the Korean government formulated a document to shape national policy on mental health care across the country. According to the Government Plan for Community Mental Health Care 2000, it was government policy to encourage community-based facilities on the grounds that it is cheaper, cost effective and more suited to earlier treatment and rehabilitation (MoHW, 2000). There is no doubt at all that there is a model of community care in Korea, and some outstanding examples of projects have been designed by Korean people with Korean conditions in mind. In addition the government has attempted to set up alternative structures for psychiatric care, located outside the mental hospital to promote community integration. There has been the development of out patient and day patient services outside of the hospital and a range of new community-based treatment facilities have been established. These include community mental health centres, and the establishment of multidisciplinary community-based psychiatric teams involving general practitioners, community psychiatric nurses, psychiatrists, psychologists, social workers and some other staff groups (see section 8.3.4).

The Korean government has also sought to establish new alternatives in the community. Consequently Community Mental Health Centres (CMHCs) and Social Rehabilitation Centres (SRCs) have been created in catchment areas. This model has been formed on

the basis of a unifying mould of mental treatment and social welfare services. The support of various services as a dimension of social welfare other than mental services based on a medical model should be guaranteed since broad service more than prevention, revival and rehabilitation is needed rather than the treatment for mental disorders.

In addition, in order to protect the human rights of people with mental health problems and reduce the number of long-term inpatients in mental hospitals or institutions, the Government has introduced several projects or programmes. First of all, the government began to evaluate psychiatric asylums, especially their openness, quality of service and the satisfaction of inmates. Secondly, local government as well as central government has been increasing investments in the public mental health programme. Thirdly, by the Mental Health Act, each local government introduced the compulsory peer review system for extending the length of stay over six months in institutions. Fourthly, by the Mental Health Act the Government began to regulate the size of mental hospitals, which prohibited constructing new mental hospitals with more than 300 beds. In addition, the Government and many NGO's have been participating in a variety of campaigns to remove prejudice against those with mental health problems; finally, the Government is now trying to achieve up-to-date epidemiological data about mental illness and alcohol abuse. From 2000 to 2002 a nation-wide epidemiological study was conducted to check the prevalence of mental illness, socio-economic characteristics of people with mental health problems and their mental health service utilisation patterns.

8.2.2. New Mental Health Act 2000

The main aim of the New Mental Health Act 2000 was reintegrating people with mental health problems into the community. The Mental Health Act 2000 formalised this endeavour by restricting the number of beds (no more than 300) in mental hospitals. This act outlined a number of changes. A central element was the building of a comprehensive network of psychiatric facilities (including general hospital units, CMHCs, SRCs), administered within each catchment area. In addition the private and voluntary sectors were encouraged to provide much of social rehabilitation services and programmes. The Act also gave local authorities the powers to run publicly funded mental health centres for those with mental health problems.

As has already been mentioned, Korea proved to be the main exception to this general policy trend until 1997. Long-term institutionalisation was the main method of treatment and care for people with mental health problems. The average length of stay in a Korean mental hospital in 1996 was 136 days, 12 times the average stay of patients in the United States. However, like many other industrialised countries Korea has developed community-based policies for people with mental health problems. For example, the government has made substantial progress in transferring mental health service users from institutional to community settings in recent years. In 1995 mental health legislation was implemented which seeks to increase patient rights and to avoid unnecessary hospitalisation. In 2000 the health and welfare minister endorsed a National Mental Health Policy. This laid out plans to promote the development of community-based services, together with their better integration with remaining institutional services. In recent years, the government has encouraged and supported the

development of rehabilitation programmes. The Mental Health Law of 2000 provides support for a shift in policy towards supporting to some extent the reintegration of people with mental health problems into the community, although implementation of this has been slow.

8.2.3. Building the National Mental Health Service Delivery System

As the Korean government embarked on a productive welfare approach, mental health was not adequately addressed (see discussion in chapter 7). The National Mental Health Service Delivery System was a set of recommendations developed to ensure that mental health care was explicitly included.

The early draft of the National Mental Service Delivery Systems was formulated by mental health professionals and then subsequently adopted by the Ministry of Health and Welfare, the highest health policy-making body at national level. The major recommendations were that:

- (a) Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of health, education, and social welfare;
 - (b) Strengthening the mental health component in the curricula of various levels of health professionals
- (MoHW, 2000).

These recommendations were in response to the recognition that mental health professionals alone would be unable to meet the growing mental health needs of the

population. Even if training facilities for the mental health sector were doubled or tripled, it would require several decades to meet such needs. Also, it was recognised that services beyond mental health institutions were needed. One of the more important elements in the delivery of health care in Korea is the primary health centre. A major thrust of the National Mental Health Service Delivery System was to provide mental health care at and from these centres (MoHW, 2000).

The objectives of the National Mental Health Programme were:

- (a) To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population.
- (b) To encourage application of mental health knowledge in general health care and in social development.
- (c) To promote community participation in mental health services development and to stimulate effort towards self-help in the community.
- (d) To reduce the incidence and prevalence of mental health problems
- (e) To reduce mortality associated with mental health problems
- (f) To reduce the extent and severity of problems associated with specific mental health problems, including poor health and social function
- (g) To develop mental health services
- (h) To promote good mental health and reduce stigma, through, for example, public education
- (i) To promote the psychological aspects of general health care.

(MoHW, 2000)

Since its inception, the efforts of the National Mental Health Service Delivery System have been directed at promoting and developing state-level programmes, workshops for mental health professionals and voluntary organisations, evaluation of mental health care provided through primary health centres, the development of a model District

Mental Health Programme, and the development of training materials and programmes for practitioners and academicians.

Moreover, the Mental Health Service Delivery System considered adopting the 'common strategic mental health framework' suggested by the WHO:

- (a) Educate, support and resource primary care in its essential role of helping the majority of people with mental health problems.
- (b) Develop effective links between primary and secondary care, with well-developed criteria for referral, methods of shared care, adequate information systems and communication etc.
- (c) Develop comprehensive local specialist health and social services.
- (d) Develop mental health legislation, which protects human rights and controls the circumstances under which patients can be held in hospital or treated without consent.
- (e) Develop good practice guidelines on effective interventions in primary and secondary care, and on inter-agency collaboration.
- (f) Develop a package of public health measures to reduce suicides and homicides by mentally ill people.
- (g) Develop a research and development strategy for mental health.
- (h) Develop a mental health promotion strategy embracing generic settings such as the workplace, schools and general health care.
- (i) Educate school personnel about the management of mental health problems.
- (j) Involve user and carers in policy development and in service development and delivery.
- (k) If resources permit, develop mental health information systems in secondary care, incorporation core clinical minimum data sets and outcome measures that satisfy data protection and confidentiality requirements, in consultation with service users.
- (l) Develop effective links between the policy makers, the scientific community and the mental health delivery system.

(Jenkins, et. al., 1997)

The above strategic framework has been actively addressed by the introduction of the mental health centres within general health centres.

8.2.4. Introduction of Mental Health Centres within General Health Centres

The public mental health service system has been established in the last few years for the protection of people with mental health problems (Mental Health Act 2000, Section 1). It includes social rehabilitation centres for those with mental health problems, general health centres and health centres. Mental health workers have been posted in general health centres.

There have been two types of community mental health services within general health centres funded by central government budget. The first one is basic and compulsory services and the other is selective services. Basic and Compulsory Services within both General Health Centres and Mental Health Centres are:

- (a) Survey for availability of mental health related resources;
- (b) Registration;
- (c) Establishment of referral system;
- (d) Case management;
- (e) Education for users and carers;
- (f) Prevention programme;
- (g) Mental health promotion;
- (h) Campaign for reducing stigma attached to the mental illness;
- (i) Mental health consultation;
- (j) Management and co-ordination of volunteers.

(MoHW, 2001).

Basic and compulsory services within only Mental Health Centres are:

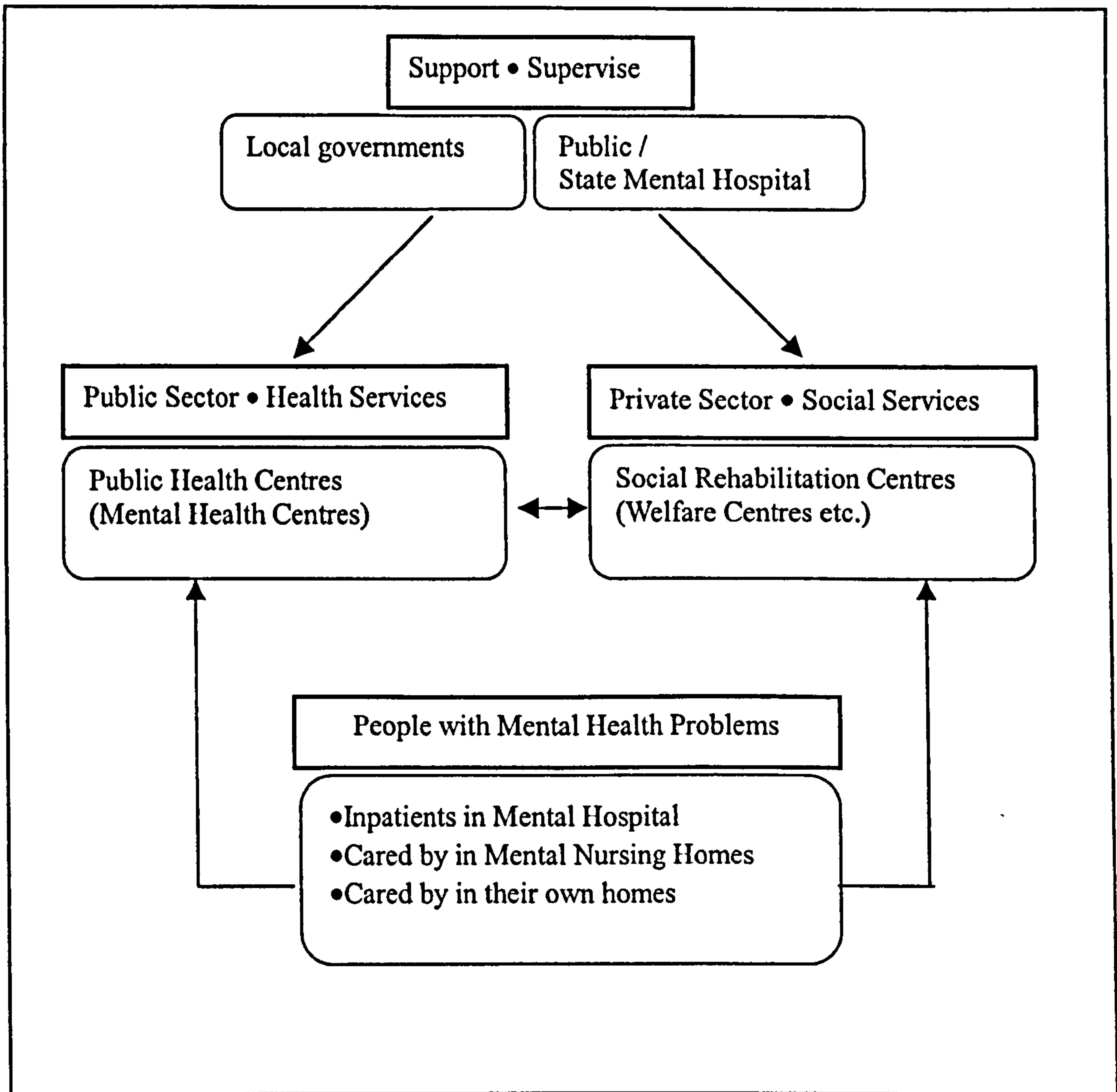
- (a) Support for the meetings of families;**
- (b) Day care programmes;**
- (c) Occupational rehabilitation programmes;**
- (d) Education for mental health professionals;**
- (e) Mental health services seminars;**
- (f) Regular meetings for consultation and management committee**
(MoHW, 2001).

The selective services within General Health Centres and Mental Health Centres are:

- (a) Rehabilitation programmes for people with alcohol and substances abuse;**
- (b) Mental health services for the elderly;**
- (c) Mental health research;**
- (d) Support residential homes;**
- (e) Emergency services;**
- (f) Mental health services for children;**
- (g) Mental health services for the workplace;**
- (h) Outpatient services;**
- (i) Family support programme**
(MoHW, 2001).

Under the Korean situation where the sub structural establishment of the mental health sector is not yet solid, the public health centre model is more likely to make the most of the existing organisations, the institutions, and mental health professionals. In addition, a more organic system is likely to be more suitable for the public health centre model (see Figure 8.1.).

Figure 8.1 Public Health Centre Model



Source: Moon, 2000.

8.2.5. Establishment of Social Rehabilitation Centres

In order to protect the human rights of people with mental health problems patients and reduce the number of long-term inpatients in mental hospitals and psychiatric asylums, (Mental Health Act 2000, Section 1) the community health service system has been established.

The community mental health service system includes social rehabilitation centres for psychiatric disability, community mental health centres and health centres. Mental health workers were posted in health centres by the end of 1998. Table 8.2 shows the planning of the establishment of social rehabilitation centres and community mental health centre for the psychiatric disabled from 1998 to 2003 (Ministry of Health and Welfare, 1999).

Table 8.2. Planning of Establishment of Social Rehabilitation Centres for the Psychiatric Disabled

| | | Total | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|--------------------------------------|-----------------------------|-------|------|------|------|------|------|------|
| Social Rehabilitation Centre | Number of Facilities | 97 | 7 | 10 | 20 | 20 | 20 | 20 |
| | Budget (100 million won) | 185 | 5 | 5 | 25 | 35 | 50 | 65 |
| Community Mental Health Centre | Number of Facilities | 165 | 4 | 11 | 40 | 50 | 60 | 60 |
| | Budget (100 million won) | 65.0 | 2.0 | 7.0 | 11.0 | 13.0 | 15 | 17 |

Source: MoHW (1999) *Report of Health and Welfare*, Seoul, Korea, MoHW.

8.3. Characteristics of the Reconstructed Mental Health Policy after the Crisis

This chapter has attempted to analyse policy responses from the Korean government to deal with mental health problems in aftermath of the economic crisis of 1997. The Korean government responded to this problem by introducing the community-base mental health policy with regard to the issue of the prevalence of mental health problems and mental health service utilisation (e.g. rates of unemployment and

homelessness, and overall social deprivation). This section identifies the basic features of mental health policy and practice after the economic crisis.

8.3.1. Focus on Rehabilitation

Since the 1950s the policies of de-institutionalisation and the development of community-based services can be understood to have constituted a process of administrative recommendation; a reversal of nineteenth-century policy, with the aim being to restore people with mental health problems to the status of (wholly or at least partially) functioning members of a market economy. This framework for the development of the post-war mental health policy has had a marked impact on service development within the countries representing this regime type (Goodwin 1997, p.108).

The primary aim of these developments in service provision has been upon rehabilitation; the underlying theme of this being that people should be helped to regain their independence within a market economy. In England, for example, concern over the effects of mental health problems upon industrial efficiency rapidly became apparent in the immediate post-war period (Goodwin 1997, p.108).

This focus of service development upon the restoration of mental patients to labour market activity also characterises other liberal regimes (Goodwin 1997, p.108). In the United States, as de-institutionalisation got under way and the community mental health centres movement was emerging, a clear policy emphasis was placed upon rehabilitation:

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalisation as much as possible, (2) if the patient requires hospitalisation to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. (Joint Commission on Mental Illness and Health, 1961)

The fact is that, for many people subsequently discharged from mental hospital, rehabilitation has proved unrealistic and has often tended to obscure this aim, but as a goal it tends to be central to the rationale for providing community-based services within liberal regimes (Goodwin 1997, pp.108-9).

In this respect, it could be argued that the main focus of mental health policy in Korea in the aftermath of the economic crisis was a liberal approach, which emphasises rehabilitation of people discharged from mental hospitals. To achieve this goal the Korean government has established social rehabilitation centres (see Table 8.3).

This has been the solution of many social reintegration programmes in the West. True to adopting Western mental health forms, the relatively few Korean community-based mental health programmes that exist frequently voice the same goal. The appropriateness of this goal is questionable in the Western context, but it is incomprehensible in a Korean context, where one's relationship to the social group is so important.

Table 8.3. Social Rehabilitation Centres

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|----------|------|------|------|------|------|------|
| Total | 6 | 16 | 36 | 94 | 178 | 272 |
| Seoul | 4 | 5 | 9 | 13 | 21 | 21 |
| Busan | 1 | 1 | 2 | 5 | 7 | 7 |
| Taegu | 1 | 2 | 2 | 7 | 9 | 10 |
| Inchon | - | - | 1 | 1 | 1 | 2 |
| Gwangju | - | - | - | 2 | 3 | 3 |
| Taejeon | - | 1 | 3 | 9 | 15 | 17 |
| Ulsan | - | - | 1 | - | 1 | 1 |
| Kyonggi | - | 1 | 3 | 9 | 15 | 17 |
| Kangwon | - | - | - | - | 1 | 1 |
| Chungbuk | - | - | - | - | 2 | 4 |
| Chungnam | - | - | - | 3 | 3 | 4 |
| Chunbuk | - | - | - | 6 | 8 | 9 |
| Chunnam | - | - | - | 1 | 1 | 1 |
| Kyongbuk | - | - | 2 | 3 | 3 | 4 |
| Kyongnam | - | 2 | 2 | 3 | 3 | 3 |
| Cheju | - | - | - | 1 | 2 | 2 |

Source: MoHW (2003) *Mental Health Facilities Yearbook*, Seoul, Korea, MoHW.

Another option is to reintegrate people with mental health problems into viable subcultures. However, even the subcultures that exist in Korean society are not officially recognised, or certainly not recognised as viable. Like individualism, sub-cultural or group identity that falls outside of the norms for general Korean identity is to be avoided. Those who opt for independence or a subculture in Korea pay a tremendous social and emotional cost for it. In this situation, individuals with mental health problems have little chance in the community outside the family.

The lack of beds is one of the main problems within the mental health system in Korea. Due to the lack of psychiatric hospital beds those with mental health problems,

estimated at 19,000 patients, are accommodated in inappropriate mental health facilities. Furthermore, there is a limited number of facilities which provide rehabilitation services and programmes. Consequently, the revolving door syndrome has appeared. It is recognised that, particularly for patients with schizophrenia, the cycle of admission and discharge is too frequent. It is suggested that patients are sometimes discharged inappropriately and that the support services available in the community are inadequate, both tending to result in the mental health of the patient deteriorating and consequently resulting in readmission.

8.3.2. Devolution

In February 2000, the Ministry of Health and Welfare announced a national policy of community-based care for those with mental health problems. This policy statement mentioned that chronic patients should be discharged from mental hospital into the community where they could be offered services by local authorities in the community mental health centres and social rehabilitation centres. Local authorities have no separate mental health policy and programme. National mental health policy is decided by the Division of Mental Health at the Ministry of Health and Welfare.

The community mental health centre (CMHC) is considered as one of the most useful and comprehensive models in community mental health. Since 1995 about 20 CMHCs have been established in Seoul and Kyunggi province throughout Korea. Each CMHC has its uniqueness and progresses according to the characteristics of its local community (Lee, J., 1998).

Although under poor conditions – shortage of professional manpower and experience, lack of social support and finance – the CMHC is now developing and spreading in Korea. Lee Jong-Gook (1998) presented several problems for the future of the CMHC development. These are as follows:

A lack of legal basis, difficulty in agreeing with the concept and role of the CMHC, poor linkage of co-worker systems with other resources and agencies in the community, and the adequacy of the tools and methods for the evaluation of the effect and outcome of the CMHC (p.28).

The development of the CMHC requires consistent and continuous effort from mental health professionals, administrative concern and support, consumer (patient and family) participation, and community support (Lee, J., 1998)

According to the Guidelines for Community Mental Health set by the Ministry of Health and Welfare (2002), local authorities should allocate the budget for community mental health services from their budget. Seoul Metropolitan City receives 40 per cent of its budget from central government whereas the other local authorities are given half of their budget from central government. This means that the local authority has the responsibility for spending on community mental health services even though this does not include medical fees for the majority of inpatients. These fees are mostly covered by national insurance schemes or by the Government Medical Protection scheme (for the poor). However, as Table 8.4 demonstrates, without strong state financial support for programming, decentralisation to community-based services for people with mental health problems and the establishment of local-level services will both be extremely difficult in the future.

Table 8.4. Community Mental Health Services within the General Health Centres (GCS) funded by Central Government 2001

| | Number of General Health Centre | Number of GHC funded by Central Government Budget |
|----------|---------------------------------|---------------------------------------------------|
| Total | 242 | 16 |
| Seoul | 25 | 1 |
| Bussan | 16 | 1 |
| Taiga | 8 | 1 |
| Intone | 10 | 1 |
| Gong | 5 | 1 |
| Taejeon | 5 | 1 |
| Ulsan | 5 | 1 |
| Kyonggi | 39 | 1 |
| Kangwon | 18 | 1 |
| Chungbuk | 11 | 1 |
| Chungnam | 15 | 1 |
| Chunbuk | 14 | 1 |
| Chunnam | 22 | 1 |
| Kyongbuk | 25 | 1 |
| Kyongnam | 20 | 1 |
| Cheju | 4 | 1 |

Source: MoHW (2003) *Mental Health Facilities Yearbook*, Seoul, Korea, MoHW.

8.3.3. Maximising the Role of Private and Voluntary Sectors

Since the 1960s, the Korean voluntary sector has been involved over time in mental health service provision in various ways. The for-profit sector, active on residential care provision, has relatively limited experience in the delivery of services to people with severe mental health problems. As community-based services have developed in Korea, the voluntary not-for-profit sector had been much involved, and the for-profit sector hardly at all.

In 1999, there was also the symposium on the Development of a National Mental Health System organised by the Ministry of Health and Welfare. This symposium discussed the development of a national mental health system through delegation to the private sector. Lee, Young-Moon suggested maximising the role of private and voluntary sectors as follows:

The policies of public mental health system have been advanced through cooperation and confrontation between public and private parts in developed countries. For development of adequate public mental health policies, the indicators of public mental health should be established and information of private practice should be connected to central government. Also, the sense of responsibility and accountability of mental health professionals is essential. The central government and local autonomies have to reassign the responsibilities of mental health. Therefore, the privatization of publicity should be effective in the actual practices. Also the management and control of actual practices need to be delegated to the local government and the central government should manage the whole mental health system and make an effort to get budget. Thus the decentralization of mental health services is very important. Also, NGO would play a very important role in development of national mental health policies (Lee, Y. 1999, p.22).

According to the Mental Health Act 2000, the government encouraged the private and voluntary sectors to provide much of the social rehabilitation services and programmes. As a result of this, there has been an increasing number of voluntary and private organisations that are offering mainly residential, community support, and vocational training services.

The aim of the community-based mental health care model is to minimise the coverage of formal welfare and, at the same time, to maximise the role of private organisations.

Private organisations are required to widen their activities, not only as non-formal providers, but also as subcontractors of public services. In order to amplify private activities, the government provided financial support to private agencies and relaxed restrictions on their services.

8.3.4. Different Service Providers

As Table 8.5 shows, there have been different mental health service providers since the late 1990s. These include mental hospitals, departments of psychiatry within general hospitals, psychiatric clinics, mental health centres, and social rehabilitation centres. In addition, the 'psy complex', the multidisciplinary mental health team has emerged.

Table. 8.5. Different Mental Health Service Providers: 2001

| | | No. of Facilities | No. of Beds | % |
|--------------------------------------------|----------------------------------------|-------------------|-------------|------|
| Mental Hospitals | National/Public | 17 | 7,570 | 13.0 |
| | Private | 61 | 2,067 | 35.5 |
| | Sub total | 78 | 9,637 | 48.5 |
| General Hospitals / Psychiatric Clinics | Dept. Psychiatry (General Hospital) | 149 | 6,170 | 10.6 |
| | Psychiatric Clinics | 522 | 9,468 | 16.3 |
| | Sub total | 671 | 15,638 | 26.9 |
| Sub total | | 2,498 | 50,550 | 75.4 |
| Mental Health Centres | | 46 | - | - |
| Social Rehabilitation Centres | | 48 | - | 0.4 |
| Total | | 1,601 | 64,685 | 100 |

Source: MoHW (2001) *White Paper of Health and Welfare*, Seoul, Korea, MoHW.

8.3.4.1. Mental Hospitals

As Table.8.5 shows, in 2001 there were 78 mental health hospitals in Korea. The total number of beds was 9,637. These hospitals are categorised as follows:

(a) National/ public hospitals: 7,570 beds;

(b) Private hospitals: 2,067 beds.

In Korea, mental hospitals have by far the largest resources in mental health manpower. Even a majority of community mental health programmes are supported by staff members of mental hospitals. Mental hospitals deal with patients with behaviour and emotional symptoms. Compulsory admission based on the Mental Health Act is one of the major responsibilities of mental hospitals. Public funds are provided for: the treatment of patients; hospitalisation under the medical protection scheme; and the compulsory hospitalisation scheme. Local government support services are related to emergency mental health care. They collaborate with mental hospitals in the community to develop rotational responsibilities for emergency care on holidays and at night time.

8.3.4.2. Mental Health Beds in General Hospitals

University hospitals have a small number of psychiatric beds, and are used as teaching hospitals for medical students and post-graduate students. In Korea, very few general hospitals have psychiatric wards. However, an increasing number of general hospitals employ psychiatrists for liaison services, particularly for terminal cases.

8.3.4.3. Psychiatric Clinics

As Table 8.5 shows, the official number of psychiatric clinics in Korea is 522, a figure which includes clinics run by internists and neurologists, who are permitted to treat mental patients. This has been the category of mental health service with the fastest growth-rate in Korea.

8.3.4.4. Mental Health Centre

Mental Health Centres plays a key role in mental health in terms of promotion, prevention and rehabilitation. They are also expected to provide technical guidance and support for mental health activities carried out at other health centres.

8.3.4.5. Social Rehabilitation Centres

In 2001, there were 48 social rehabilitation centres. Currently, there are two types of psychiatric rehabilitation services in Korea: (a) social skills training; (b) occupational rehabilitation. Occupational rehabilitation emphasises the education and training aspect of rehabilitation and integrates its programmes with the treatment service. In Korea, occupation rehabilitation is provided by different organisations and at different levels of occupational training. The least demanding facilities in which occupational

rehabilitation has been provided are the psychosocial clubs of ‘Samsoknunjib¹’, day care rehabilitation services are provided within outpatient clinics and day care facilities. Occupational rehabilitation is most intensive in those special facilities that prepare the person for a competitive job outside the mental health system.

8.3.4.6. The Emergence of the ‘Psy Complex’

The occupational groups which claim an expertise in mental health, sometimes called the ‘psy complex’, include psychiatrists, clinical psychologists, mental health social workers, mental health nurses, psychoanalysts, psychotherapists and counsellors (Rogers and Pilgrim 2001, p.20). As mentioned earlier, the multidisciplinary mental health team has emerged since a range of community mental health services outside mental hospitals have developed (see Table 8.6).

Table. 8.6. Mental Health Professionals 2000

| | | Psychiatrists | Nurses | Social Worker | Clinical Psychologists |
|-----------------------------------------|-------------------------------------|---------------|--------|---------------|------------------------|
| Mental Hospitals | National/Public | 122 | 651 | 35 | 18 |
| | Private | 223 | 945 | 134 | 34 |
| General Hospitals / Psychiatric Clinics | Dept. Psychiatry (General Hospital) | 362 | 837 | 142 | 114 |
| | Psychiatric Clinics | 586 | 503 | 79 | 31 |
| Total | | 1,293 | 2,936 | 390 | 197 |

Source: MoHW (2000) *National Mental Health Service Delivery System*, Seoul, Korea, MoHW.

¹ American style fountain house club

8.3.5. Government as a Regulator rather than Provider?

Following the economic crisis the government has been expected to assume a social welfare responsibility for people with mental health problems, taking this responsibility from the family. While there has been a willingness to do this for other populations (for example the elderly), the government has displayed consistent ambivalence about assuming this responsibility for people with mental health problems. This ambivalence is again reflected in the 2000 revisions to the mental health law. The revised law first asserts that local and central government have the responsibility to promote the independence of people with mental health problems. It then creates health and welfare benefits for people with mental health problems that parallel similar benefits for people with physical disabilities and for those with developmental impediments.

If the reforms in the law were truly aimed at the rehabilitation and reintegration of people with mental health problems, one would expect to see a significant portion of financial support for people with mental health problems. However, central and local governments have yet to mount serious efforts in this area (see Table.8.7).

Table. 8.7. Mental Health Services Budget (1999-2000) (unit: 1,000,000 won)

| | 1999 Budget (A) | 2000 Budget | | Increase (B-A) |
|------------------------------|--------------------|-------------|-------------------|-------------------|
| | | Claim | Adjustment (B) | |
| Total | 18,206 | 32,257 | 22,557 | 4,351 |
| Mental Health Nursing Home | 17,513 | 21,172 | 19,812 | 2,229 |
| Social Rehabilitation Centre | - | 2,718 | 1,000 | 1,000 |
| CMHCs | - | 690 | - | - |
| Public Mental Hospital | 693 | 4,359 | 2,745 | 2,052 |

Source: MoHW (2000) *National Mental Health Service Delivery System*, Seoul, Korea, MoHW.

There have been limited resources within mental health services, and a consequent dearth of money for the development of new community-based care services. A result of this, there have been growing levels of criticism of the inadequate level of support available to discharged patients or to service users who have never been admitted. Indeed funding of community-based care is generally acknowledged to be inadequate.

In this respect, the state has tended to play the role of regulator rather than that of provider in the mental health care system in the aftermath of the economic crisis. Consequently, although the 2000 law and National Mental Health Plan 2000 create a significant policy for people with mental health problems, the limited number of programmes available in the community limit the usefulness of the provision. In particular, many services have been insufficiently developed to meet existing levels of need.

8.3.6. The Continuation of Family Care without Adequate Support

As explored in Chapter 7, family care was a crucial resource in caring for those with mental health problems, and the state stood back from service provision in Korea. There was an emphasis on familial responsibility rather than on the responsibility of the state to ensure the wellbeing of its citizens even though the ability of families to provide care was decreasing during the industrialisation period. In the aftermath of the economic crisis, demographic changes, rising divorce levels, increased geographical mobility and increased women's participation in the labour market are all tending to reduce the capacity of informal carers to provide care. However, the government's policy shift

towards community care tends to see family care as a crucial resource in the mental health care system.

The assumption underlying the introduction of a community-based mental health system, that patients would receive support in the community and would thereby benefit from being discharged, has proved overly simplistic and sometimes erroneous. In this respect, one issue in particular may have received considerable attention. Are families able or willing to adopt the role ascribed to them within the community care policy?

The debate revolving around the shift towards community care often includes the implicit reliance on families of the mentally ill to assume a large part of the caring responsibility. The Korean experience has proved no exception to this.

Table 8.8. Destinations of Discharges 2000-2002

| Classification | No. Of Institutions | Discharges | | | | |
|----------------|---------------------|-----------------------|----------------------|----------|--------|--------|
| | | Families or Relatives | Employment With Care | Transfer | Deaths | Others |
| 2000 | 55 | 1,910 | 24 | 389 | 136 | 328 |
| 2001 | 55 | 1,562 | 94 | 268 | 115 | 74 |
| 2002 | 55 | 1,413 | 73 | 252 | 156 | 144 |

Source: MoHW (2003) *Health and Welfare Statistical Yearbook 2003*, Seoul, Korea, MoHW.

Table 8.8 demonstrates the number of the discharged patients who have returned to their families or relatives. In this context, families have continued to play a role for caring for their mentally ill members.

To achieve the full participation in society which the government has emphasised, a fuller range of services to help people achieve an income, transport facilities and housing comparable to those around them should be required. However, the reconstructed mental health policy tends to have an inadequate range of community care facilities.

The reconstructed mental health policy therefore has further problems for a community-based support system. The lack of employment opportunities, and the lack of services to support people with mental health problems in finding and holding on to employment, is characteristic of a mental health service after an economic crisis.

As a result of this, there has been a tension between the increased emphasis given to the role of the informal carer within mental health policy as the Korean government has introduced a community-based scheme which assumes that families want to care, and those with mental health problems want to be cared for by their families. Accordingly, the main burden of care falls upon women. This still tends to be ignored by policy makers.

In Western countries, feminist critiques of community care argue against the reliance it has on informal support as the responsibility of caring often falls on women (Dalley, 1988). Similarly, the contemporary role of Korean women is one of double presence, in managing major responsibilities both at home and in the work place (Sung, 2002; Won, 2004). Korean women are likely to find themselves responsible for the care of mentally ill relatives.

8.4. Summary

This chapter has explored the restructuring of mental health policy after the changing economic situation. Some social changes and new trends have been found: an ageing society, a globalising economy, a growing demand for social welfare, and a decline of the capacity for informal care and pressure on public spending. These changes and new trends have important implications for future social policy making in general and mental health policy in particular. It reflects the government's declared aims: to adapt the social welfare system to the new global (capitalist) market economic system, to stimulate economic efficiency in a marketising and globalising environment, and to maintain political stability by solving newly produced social problems such as urban unemployment and poverty, which are mainly caused by market reform and international competition. To achieve these aims, the Korean government has attempted to adopt a new form of welfare called the 'productive welfare model'. Some argue that this model contributes to the expansion of social welfare. On the other hand, this policy displays neo-liberal characteristics as a result of welfare reform, moving towards a liberal welfare regime. For instance, there has been a neo-liberal approach to mental health care, which is the policy shift towards community-based services. The government attempted to establish community mental health centres within public mental health centres and social rehabilitation centres for people with mental health problems. The main focus of this approach is rehabilitation, which liberalists emphasise.

However, the 'Confucian governmentality' could be utilised by policy makers to provide a rationale for their policy making and to cope with economic difficulties, even though neo-liberal tendencies have been detected in Korean policies since the economic

crisis of 1997. Accordingly, the mental health policies after the crisis were informed and shaped by repeated affirmation of the values and practice of Confucianism.

In addition, it is hard to say that the role of the state has been strengthened in the mental health policy arena even though the state came to take increasing responsibility for the financing of the other welfare programmes (e.g. unemployment programmes) (see Chapter 6). For instance, the aim of the community-based mental health care model is to residualise the coverage of formal welfare while maximising the role of private organisations. Private organisations are required to widen their activities, not only as non-formal providers, but also as the subcontractors of public services. In order to amplify private activities, the government has provided financial support to private agencies and relaxed restrictions on their services.

Chapter 9. Discussion and Conclusion

This study focuses upon the initiation of the mental health policy in Korea. The study found the importance of analysing the cultural/political context of public administration in Korea and its contribution to understanding policy. This chapter tries to review the findings and insights gleaned from this study's analyses, and discuss the relevance and utility of its topics.

The chapter is divided into three sections. The first section summarises findings from the four analytic chapters: reflects on how these relate to previous findings and assertions concerning the historical evolution of mental health policies and mental health services in Korea and discusses which factors have primarily influenced mental health policy making. In the second section, the study's insights and contributions to mental health policy development and policy making are examined. This second section also highlights the contribution the findings make to the body of policy development and policy making in the mental health arena. Section three intends to present 'positive mental health services' in Korea.

9.1. Mental Health Policy Making under the Confucian Governance

This study adopts the work of Michel Foucault in order to develop further a set of tools for analysing mental health policy in Korea. Through the analysis, the government's

rationale for fostering 'Confucianism' has been examined in order to look at the moral discourse on the family in terms of technologies of Confucian governance. This section more closely examines Foucault's suggestions concerning the rationality of contemporary strategies of governing of mental health problems.

9.1.1. The Emergence of Mental Health Policy under the Confucian Governmentality

9.1.1.1. The Birth of the Mental Health Policy as a Technology of Control

In chapter 7 and 8 this study found the factors affecting the development of a mental health policy in Korea. A number of factors contributing to the promotion of mental health policy have been found. Rapid industrialisation and urbanisation resulted in the social and occupational displacement of many Koreans. These changes produced the problem of the undermining of the traditional family and community systems of social support and control for those with mental health problems. Due to these factors, the government appears to have shown neither the capacity nor the inclination to develop a modern range of social policies and institutions. To this end the government attempted to establish a plan to promote a mental health care system. The plan included: the protection and improvement of the mental health of the population; the respect for human rights and assessment of the needs of people with mental health problems; a project for the examination of the current status of the mental health system; the establishment of mental health legislation to codify and consolidate the fundamental principles, values, and objectives of the Korean mental health policy.

As mentioned earlier, Korea delayed establishing a clear policy for the treatment of people with mental health problems. Not until 1995 was a Mental Health Act passed by the National Assembly and this did not come into force until March 1997. As Neary (2000, p.164) points out 'until then, and many would say even now, psychiatric health was treated as a social order issue'. The Act committed the state to placing greater emphasis on community-based mental health care, although the programme to create these community-based facilities is progressing slowly and the number of people being hospitalised has continued to increase.

In this regard, the Korean government attempted to enact the Mental Health Act 1995 and to develop mental health services. There was low priority for mental health care until the 1980s in Korea. People with mental health problems were cared for by their families and communities rather than by the state. Since the 1980s there have been remarkable advances and an understanding of and response to mental health problems from both the state and the public. There has also been a greater recognition of the need to promote mental health service provision.

9.1.1.2. Maintaining Social Order

This study has attempted to examine the mental health policy since the 1960s. Through this examination some main features of Korean mental health policy have been found. First of all, social control (custodial confinement) was a central policy concern to deal with those with mental health problems rather than their treatment and care. Second, a strong medical approach was adopted to cope with those who have mental health

problems rather than the adoption of other approaches. Lastly, it is more than likely that the government's intervention for people in need of psychiatric treatment and care was weak and conservative. It means that government-based assistance was by no means widespread, and for the most part households were obligated to assist their own family member who had mental health problems.

Social order is about people fulfilling their social roles and meeting other people's expectations of them (predictability). Social orders change and differ between (and within) societies. The argument to make is that the state, in emphasising Confucianism, is emphasising that families are responsible for their dependants (part of the social order it wants to maintain) including people with mental health problems. However, for the family to maintain its 'normal' social functions and expectations in the public arena it often discharges its care responsibility by 'buying in' psychiatric services via health insurance. This enables both family members to work.

Inequalities arise when families cannot afford private insurance, and have to provide care directly themselves, as this disrupts their other social roles - such as going to work. This reduces family income just when there is greater dependency on it - not a good basis for care.

To study the Korean welfare system, it is important to discuss the grand view of its system at the level of social order. This 'social order' can be defined structurally as social stratification reflected through class structure, as Marxists underscored in their analysis of the capitalist order. In Weber's (1978) work, however, this 'social order' was institutionally defined as a 'legislated order' of society validated by law and still

normatively, by affection, value rationale and religious beliefs. When mental health policy is in question, the social order will affect the type of mental health policy by structuring the basic environment of policy making and constituting its organisation and services, while, in return, mental health policies restructure the services that exert their influence on social order. This 'dialectical' relationship indicates the necessity of a social order study to understand the 'dynamic' of mental health policy making, since it is the social order that defines the role of welfare agents and their production of motion in mental health policy making process.

The Korean government considered cultural factors before they formulated the policy. It is not surprising that the policy maker focused upon the family as a major welfare resource. They also realised that Confucianism still plays an important role in shaping people's attitude to life in Korea. This has been institutionalised as an orthodox ideology since the Chosun dynasty (1392-1910). In this respect, it is important to examine how the Korean government reasserts social order to shape the new mental health policy towards community based service provision for people with mental health problems, particularly for those discharged from mental hospitals and the other institutions.

Furthermore, an overriding feature of the Korean mental health policy since the 1960s has been its concern for maintaining social order and the perception that those with mental health problems somehow contribute to social disorder. This makes analysing the policy paradoxical for those domestic and international critics who view the policy from other vantage points, such as treatment. Additionally, those who view the Korean social welfare system as unified, with a single, progressive purpose, were similarly

influenced by mental health policy. Mental health policy appeared inconsistent with other social welfare goals and practices.

9.1.1.3. Caregiving Obligations in Mental Health Policy: Maximisation of Family Responsibility

In the case of Korea's social policy during the process of industrialisation and globalisation, the Korean family, which stresses family obligation, has been emphasised as the basic caring unit responsible for the long-term needs of people with mental health problems, while public welfare provisions provide only limited assistance to preserve the family's welfare function. In this way, responsibility for meeting the needs of vulnerable groups has been diverted to the family system. As a consequence, individual and family work ethics have been preserved, while the financial sector has been enhanced for achieving further accumulation. It is important to stress the importance of structural factors, particularly those deriving from the nature of capitalist societies. This concerns factors such as the cost of service provision, and problems associated with the maintenance of social control.

Since the advent of community mental health, many parents have been thrust into a new role, that of a caregiver to children with chronic or often severe mental health problems. Often these children are adults who live at home and require help for day-to-day management and functioning. In addition, most of these adult children are also unemployed. This caregiving role thus puts great demands and often economic strains on parents. Women are particularly affected by this role, as research indicates that

women are much more likely than men to become primary caregivers (Tausig, Michello and Subedi 1999, p.65).

9.1.1.4. Maintaining the Confucian Patriarchal Characteristics of Informal Care

Most of the discussion of the health care system has concentrated on the provision of somatic medicine where the nuclear or extended family and the community have played a positive role in both the process of treatment and support of the patient. There has been rather less attention paid to psychiatric health care where the role of the family has been rather less positive. Indeed, as we shall see, as insurance-based health care systems which dramatically reduce the cost of institutional care have been introduced, families have been quite happy for their members experiencing mental disorder to spend very long periods of time in psychiatric hospitals. Not only is this very costly for the health care system but it is also often not in the best interest of the patient. In other words, the family or community-based orientation of the welfare system is only a 'good thing' where there is an identity of interest between what the family/community wants for the patient and what is in their best interest. When there is a conflict, when the family prefers prolonged institutionalisation to release into the community, the family orientation is likely to result in higher costs and treatment that is less beneficial to the patient (Neary, 2000).

9.1.2. Reconstructing the Confucian Governance of Mental Health

In this respect the Korean government had to reconstruct its mental health policy and its system to prioritise the needs of people with mental health problems and the needs of relatives.

9.1.2.1. Search for a New Technology of Control

The changes to the social security system in Korea in the wake of the financial crisis are paradoxical from the perspective of globalisation enthusiasts. The social security reforms have proceeded as a crucial measure in coping with soaring unemployment as well as alleviating the insecurities associated with structural adjustments. These reforms have not been limited to the establishment of a social safety net. Rather, they have been developing towards a more redistributive and comprehensive welfare system. All these reforms have taken place at the same time as the Korean economy has been fully integrated into the World market. In this respect, it is particularly important to identify how economic strategy constrained mental health policy decisions and the structure of mental health policy institutions.

Korea was one of the world's economic miracles in the three decades until 1997, when the Asian economic crisis hit. At this point Korea experienced a rapid fall in economic growth (and hence lowering quality of life), tumbling stock markets, rising unemployment, and growing social inequalities. In chapter eight I explored the restructuring of mental health policy after the changing economic situation. Some social

changes and new trends have been found: an ageing society, a globalising economy, a growing demand for social welfare, a decline in the capacity for informal care and pressure on public spending. These changes and new trends have important implications for future social policy making in general and mental health policy in particular. It reflects the government's declared aims: to adapt the social welfare system to the new global (capitalist) market economic system, to stimulate economic efficiency in a marketising and globalising environment, and to maintain political stability by solving newly produced social problems such as urban unemployment and poverty, which are mainly caused by market reform and international competition. To achieve these aims, the Korean government has attempted to adopt a new form of welfare called the 'productive welfare model'. Some argued that this model contributes to the expansion of social welfare. On the other hand, this policy displays neo-liberal characteristics, as a result of welfare reform, there was a move towards the liberal welfare regime. For instance, there has been a neo-liberal approach to mental health care, which underlies the policy shift towards community-based services. The government attempted to establish its community mental health centres within public mental health centres and social rehabilitation centres for people with mental health problems. The main focus of this approach is rehabilitation, something which liberalists emphasise.

9.1.2.2. Fiscally Sustainable Solution?: Minimisation of State Responsibility

As previously discussed in chapter 3, Scull maintains that, over the post-war period, governments in the advanced capitalist countries have become increasingly prone to 'fiscal crisis': a condition when tax revenues tend to decline while demands for social

expenditure tend to increase, resulting in a growing fiscal deficit. The process of de-institutionalisation has primarily been the result of a need to reduce costs, and the ideology of community care has provided the legitimating cover under which that programme has commenced (Goodwin, 1997). This cost-cutting thesis is persuasive in relation to this episode of policy formation. The Korean government was keen to minimise public expenditure, the encouragement of family care and involvement of the private and voluntary sector was a good opportunity to make fiscal saving.

One explanation is that the cost of institutional care became too great for a publicly funded welfare system to accommodate within a capitalist economy (Rogers and Pilgrim, 2001, p.62).

As Holliday (2000) points out, social policy is strictly subordinate to the overriding policy objective of economic growth in a productivist world of welfare capitalism. Everything else flows from this: minimal social rights with extensions linked to productive activity, reinforcement of the position of productive elements in society, and state-market-family relationships directed towards growth. Furthermore as Holliday (2000) argued, the two central aspects of the productivist world of welfare capitalism are a growth-oriented state and subordination of all aspects of state policy, including social policy, to economic/industrial objectives. Alongside these defining features a series of additional elements may be found. Policy makers might seek to pursue economic growth by facilitative means (Holliday, 2000).

President Park Chung-hee pursued a social policy motivated almost entirely by economic objectives, the influence of which it has never really thrown off (Kwon, H., 1999). In most cases social rights were extended first to industrial workers, and many

have still not been fully universalised. In the case of the National Pension Programme, introduced in 1988, a central aim was capital mobilisation during the phase of surging economic growth (Kwon, H., 1998b, 1999). Korea's other main social policy programmes are Industrial Accident Insurance (introduced in 1964), a Public Assistance Programme for the poor (1965), National Health Insurance (1977), and an Employment Insurance Programme (1995). With the exception of the Public Assistance Programme, Korea's social policy is based on the social insurance principle, and the state plays a largely regulatory role (Goodman et. al., 1997). In 1995, the public and private sectors in Korea respectively spent 10 and 1 per cent of GDP on social protection. This is a rather pure form of developmental-universalism because the Public Assistance Programme provides no more than a very basic universal safety net, and all other programmes cover only those who have paid into them (Holliday 2000, p.713).

Related to other dependent populations, older people have benefited more than others as Korea switched from a focus on economic growth to more balanced growth. In that same vein, people with mental health problems have perhaps benefited the least. Part of the explanation is certainly the relationship of social welfare and economic policy to populations and sectors directly affected by economic policy, which have benefited the most from the development of a social welfare policy. There was an implicit obligation towards those who created the rapid economic growth, and are now the elderly people. Additionally, urban and economic growth patterns have broken down the tradition of the eldest son's family caring for ageing parents. The wives of the eldest sons, on whom this responsibility fell, are often working now themselves or are otherwise unable or unwilling to assume this role because of social changes and expectations of women's roles.

Social welfare policy towards families and children has also benefited, largely driven by economic concerns. Educational policy is highly vocational and related to the needs of industry. Other family benefits are similarly tied to economic issues. Family-allowance benefits encourage families to have children, a concern as Korea experiences a declining birth rate and declining work force. In contrast, people with mental health problems have had almost no role in the Korean economy except as a commodified group for the psychiatric hospitals. As individuals and as a group, they have not been needed in the economy.

Although the government has been active in developing progressive social welfare policies for many populations in the aftermath of the economic crisis, this has been pursued most aggressively as it benefits or is an outcome of the economy. People with mental health problems do not fit into that equation in any obvious way. To that extent, they have remained beyond the concern of policy development. While there have been consistent internal critics of the Korean mental health policy at least since the 1980s, the government was notably unresponsive to them until the early 1990s.

Many industrialised countries around the world are tending towards developing community-based policies for people with mental health problems. In this respect Korea has made substantial progress in transferring mental health services users from institutional to community settings in recent years.

9.1.2.3. The Emergence of Care in the Community Policy as a new Technology of Control

Mental health legislation was implemented in 1997 which seeks to increase patient rights and to avoid unnecessary hospitalisation. In 2000 the health and welfare minister of Korea endorsed a National Mental Health Policy. This laid out plans to promote the development of community-based services, together with their better integration with remaining institutional services. The changes introduced by the 2000 Mental Health Act were part of much more widespread shifts in organisation and practice within public services introduced by the Kim Dae-jung government. The government regarded 'carers' as an important resource in the provision of community care. In the aftermath of the economic crisis the government attempted to freeze budgetary allocation to personal social services, but local authorities used their relative autonomy from central control to protect personal social services and held spending at pre-existing levels. The government attempted to encourage and recommend a new local authority department, providing a community-based and family-oriented service, which would be available to all. The policy shift of mental health services into the community has been driven by a number of forces including the idea that people with mental health problems should be treated in the same way as all other members of society.

Between 1993 and 1997 government reports and White papers, as mentioned in chapter 6, were unanimous in setting targets to accelerate the shift from hospital to community care. This period was characterised by consensus about the direction of policy and a slow but consistent expansion of state welfare services, making alternatives to hospital care possible and ensuring a gradual decline in the population in institutional care. The community care remit expanded to include other groups requiring long-term support

without medical care, and the policy focus expanded to include the prevention of entry to institutional care as well as rehabilitation in it.

The many social reintegration programmes have been a solution in Western European and North American countries. True to adopting Western mental health forms, the relatively few Korean community-based mental health programmes that exist frequently voice the same goal. The appropriateness of this goal is questionable in the Western context, but it is incomprehensible in the Korean context, where an individual's relationship to the social group is so important.

Another option would be to reintegrate people with mental health problems into a viable subculture. However, the subcultures that exist in Korean society are not officially recognised, or certainly not recognised as viable. Individualism, sub-cultural or group identity is to be avoided. Those who opt for independence or subculture in Korea pay a tremendous social and emotional cost for it because Korea retains a very strong social stigma towards mental illness, people with mental health problems, and families with mentally ill members. This excludes people with mental health problems from being considered a part of the social group. Consequently, people with mental health problems have little chance at survival in the community outside of the family.

In addition, the overall concern of mental health policy needed to change from the maintenance of social order to something else - treatment or rehabilitation through reconstructing mental health policy. In this circumstance, it could be argued that this policy making towards community based mental health policy has been highly driven by economic situation.

9.1.2.4. Family-based Service Provision?: Continuity of Fostering Confucianism and Family Responsibility

Since the late 1990s, the Korean government has established welfare provision for enhancing the caring functions of families for people with mental health problems. It means that the government began to respond to the problem of mental health because it became a social rather than a family problem when Korea's increased industrialisation led to greater urbanisation and increased population mobility. These social trends meant that families were less able to care for, or provide home confinement for, mentally ill family members.

The family is basic to the life of every human being. Its importance in Korea has for centuries been greatly reinforced by Confucian philosophy, received from China and fully accepted into Korean culture by the fifteen century. This philosophy emphasises family relationships as fundamental to the entire social fabric and includes relatives far beyond the simple parent-children household. Although the nuclear family (father, mother, children) as a living unit is becoming the norm in the big cities, the traditional Confucian view of family relationships and responsibilities continues as a strong influence on individual attitudes and behaviour (Macdonald, 1996).

In Korea, family responsibility is still the main source of the individual's social security. Governmental and private responsibility for the welfare of the unrelated individual is a new idea and only beginning to develop, as in Korea's universal medical insurance and limited pension system (Macdonald, 1996).

The government would have to be willing to assume a social welfare responsibility for

people with mental health problems, taking this responsibility from the family. While there has been a willingness to do this for other populations (for example the elderly) the government has displayed a consistent ambivalence about assuming this responsibility for people with mental health problems.

This ambivalence is again reflected in the 2000 revisions to the mental health law. The revised law first asserts that local and central government has the responsibility to promote the independence of people with mental health problems. It then creates health and welfare benefits for people with mental health problems that parallel similar benefits for people with physical disabilities and for those with developmental impediments.

If the reforms in the law were truly aimed at the rehabilitation and reintegration of mental health problems, one would expect to see a significant portion of financial support for people with mental health problems. However, central and local government has yet to mount serious efforts in this area. Consequently, although the 2000 law and National Mental Health Plan 2000 create significant policies for people with mental health problems, the limited number of programmes available in the community limit the usefulness of the provision.

9.1.3. Current Issues and Future Challenges

As examined in Chapter 8, a number of issues have arisen concerning the quality of the experience of service users and their carers within the framework of a community care

policy. It is clear that the next decade will see a continuation of the shift to community care that has characterised previous decades. The Korean government has recently released a mental health policy statement that reaffirms their commitment to decreasing hospital beds and establishing more community support. The challenge will be to implement these policies on a widespread basis so that the goal of community integration for those with severe mental health problems becomes a reality rather than rhetoric. As implementation proceeds there are a number of issues and trends that will need to be addressed.

Policies related to mental health care have made great strides towards promoting humanistic ideals and community care as a worthwhile goal. A major shift has occurred from the concept of custodial care to one that emphasises care and treatment. However, a huge gap remains between the rhetoric of this new policy and its implementation. For example, the Korean value system regarding individual rights, responsibilities, and community attitude towards people with mental health problems is not congruent with accepting people with serious mental health problems as members of the society. In the community, people with mental health problems commonly face barriers in gaining access to housing and employment. Stigmatisation is a serious concern not only for affected individuals but also for their family members. In addition, the resource infrastructure for mental health care is rudimentary and systemic advances that have taken place are largely due to political will and commitment.

Moreover, the danger is that the rhetoric of community of care can also result in an abrogation of responsibility. While the mental hospitals may not be appropriate, community values and resources may not be prepared to provide the services that are

needed. A well-meaning policy without the resources needed to back it up could mean that a person with mental health problems could be on the street, bereft of all services.

In addition, having people with mental health problems living in the community and listening to their voices may have the most significant impact on changing community attitudes, enhancing understanding of the process of recovery from mental health problems, and improving the mental health care system. In so doing, policy-makers can learn from the experiences of countries advanced in deinstitutionalisation in order to advance their own efforts in building a community-based mental health care system. Several principles of implementation of comprehensive community-based services have been identified, including (a) an appropriate place to live; (b) an adequate income; (c) a varied social life; (d) employment and other day activity; (e) help and support; (f) respect and trust; (g) choice and consultation (Mental Health Foundation, 1994) (see Section 9.3).

Moreover, mental health policy should be planned on the basis of the needs and interests of both those giving and receiving care. The dual focus of caring suggests that the focus of welfare intervention can not be placed exclusively on those with mental health problems or the carer. Current welfare provision focuses on only people with mental health problems, not on carers. In the process of allocating services for those with mental health problems, the carer's voice thus needs to be heard. Where there are potential conflicts of interest between these, service providers have to make decision in a way that the needs and interests of each are best considered together. However, it may not be easy for them to recognise the carer's needs and interests because carers are reluctant to ask for help for a variety of reasons and because service providers may make

assumptions about the care given by the carer. Social providers need to work with carers, respecting their needs, their values, their commitment to care and their feelings about continuing with caring (These will be suggested in great deal in Section 9.3.7).

9.2. Insights and Implications for Study on Policy Analysis

9.2.1. Insights and Contributions to Social Policy Analysis

This study found that mental health policy making in Korea has been primarily driven by two crucial structural changes in modern Korean history: industrialisation and the economic crisis of 1997. In the last three decades, both developed and developing countries have cut back on their social expenditure and retrenched state welfare. The dominant economic philosophy, heavily influenced by neo-liberalism, is antagonistic to state intervention. It is widely believed that government involvement is an impediment to economic growth. In this respect the Korean government has considered that the new direction for social policy cannot ignore fundamental commitments to economic policy. This is characterised by a commitment to low inflation and stable conditions of growth.

It is clear that the next decade will see a continuation of the shift to community care that has characterised previous decades. Most of the provinces (regions) in Korea have recently released mental health policy statements that reaffirm their commitment to decreasing hospital beds and establishing more community support. The challenge will be to implement these policies on a widespread basis so that the goal of community integration for those who are most severely ill becomes reality rather than rhetoric. As

implementation proceeds there are a number of issues and trends that will need to be addressed.

9.2.1.1. Structural and Cultural Influences in Emergence of Mental Health Policy

In Korea the issue of mental health care was the result of demographic, social and economic changes caused by modernisation and the increasing need for a welfare state. The tradition of family care and the relatively small numbers of mentally ill people in the total population made family care and carers invisible in the Korean welfare system. Families were always regarded as resources available to support and care for those with mental health problems. As discussed in Chapter 5, rapid and comprehensive changes which have occurred in Korean society since the 1960s gave rise to increasing public concern over the care needs of people with mental health problems and the capacity and availability of families to provide such care. The Korean government began to respond to this issue.

The literature on the welfare state has recently explored the uniqueness of the East Asian or Confucian welfare model as distinguished from that of the Western welfare states. The analysis of Korean social policy for those with mental health problems demonstrates some features of the former, particularly in relation to the interplay of the cultural tradition in making social Policy. The Confucian tradition sees the family as the unit primarily responsible for social welfare. The Korean government has used this Confucian tradition as its political rhetoric to rationalise the development of welfare policy as an integral part of economic development and to avoid public pressure on it to

develop certain welfare provisions, especially for those with mental health problems. The government has also attempted to encourage families to take care of their mentally ill members and puts the main responsibility for caring on them through policies promoting the Confucian tradition.

9.2.1.2. Mental Health Policy under the Globalising Process

This study found connections between globalising processes and mental health policy making in Korea. The policy making has been highly influenced by globalising processes even though there have been some progressive developments of welfare provision in the aftermath of the economic crisis in 1997. However, this is mainly in the area of social security benefits for the unemployed and not health and social services provision. Some commentators (Kim, Y. M., 2001; Kwon, H., 2000; Shin, 2000a) claim that Korea has experienced welfare expansion. Kwon, H. (2001) provided an interesting test case for the debate on the globalisation hypothesis which suggests that the role of the state will decrease. He concluded that 'although globalisation acts as a downward pressure on expenditure in some countries, it has exerted an upward pressure in the case of Korea' (Kwon, H. 2001, p.213). Shin (2000a, p.104) also points about that 'the changes to the social security system in Korea in the wake of the financial crisis are paradoxical from the perspective of globalism enthusiasts'.

The reforms have proceeded as a crucial measure in coping with soaring unemployment as well as alleviating the insecurities associated with structural adjustments. They have not been limited to the establishment of a social safety net. Rather, they have been developing towards a more redistributive and comprehensive welfare system. All these reforms have taken place at the same time as the Korean

economy has been fully integrated into world markets (Shin 2000b, p.104).

However, they have just attempted to generalise from social security benefits to the welfare state. There is no evidence from this study to support the view that Korea has developed towards a more redistributive and comprehensive welfare system. For example, there has been 'the globalisation-driven pressure on the increasing role of the private sector in the health care system' (Kwon, S. 2002, p.280).

Globalisation provides both opportunities and challenges to mental health policy in Korea. Through the diffusion of policy innovations, other countries' experience provides important lessons for mental health reform in Korea. However, when globalisation provides an external pressure towards more competition and market mechanisms without taking into account the unique institutional context of Korea, it becomes a challenge. The recent economic crisis and its impacts on mental health and mental health care in Korea is a good example of global pressures. More markets or privatisation in the mental health care system, which vested interest groups strongly support, is likely to result in deteriorating solidarity in Korea, for the role of the public sector is very limited.

In this respect, the discussion presented here has some clear implications for an understanding of the relationship between globalisation and mental health policy. The impact of globalisation on mental health policy will not necessarily be harmful but will be dependent on the structure of the social foundation. Indeed, Confucian governance still matters in the development of the welfare state even in an era of globalisation.

9.2.2. Contributions to Comparative Mental Health Policy Analysis

Chapter 3 reviewed the strengths and weakness of theoretical approaches to understanding and interpreting policy formation and development in the mental health field. However, as Goodwin (1997) has pointed out in his analysis of mental health policy in Western Europe and North America, traditional theoretical frameworks have failed to analyse policy developments within late capitalist welfare states accurately. In this respect, this study might have contributed to comparative mental health policy analysis in terms of the advantage of engaging and learning from the specific experience of different countries. As Rogers and Pilgrim (2001, p.16) have argued 'comparative analysis of systems of cultural beliefs about mental health are also important in understanding prevailing systems of care and the adoption of particular policy and practice'. Also Lefley (1999) has also pointed out the importance of cultural belief systems in understanding mental health policy developments:

Cultural belief systems inform whether deviant behaviours are identified and classified as illness, the concepts of etiology and cure, and the designation of appropriate healers. In any cultural system, modal concepts of mental illness, help-seeking paths, and utilisation patterns are intermeshed with the organisation and structure of service delivery systems.... Additionally, a culture's assessed needs for social control and order, its prevailing philosophies and legal protections, and its economic organisation and resources all have had a significant impact on the structure of mental health service delivery systems. (Lefley 1999, p.567)

Accordingly, this study has provided an opportunity to draw attention to and learn about the specific experience of Korean mental health policy making in terms of its cultural belief system. Also the study has presented the point that over the past three decades Korea has incarcerated many more patients on an involuntary basis than European

countries. Perhaps this reflects the gravity with which transgressions of social norms are viewed in Korean society.

Through an examination of Korean mental health policy developments this study found that relatively few resources are currently available which enable this research to examine mental health programmes and policies from a comparative standpoint. Given the diversity of cultural values, political and economic structures, and social welfare and health policies around the world, it is not surprising that major differences exist between nations in the treatment they provide to people with mental health problems (Benson, 1996). However, literature on comparative mental health policy mainly focuses on North American and West European countries, which may be less relevant to East Asian countries, such as Korea. Another often-missed point in this literature is the importance of cultural factors on societies and social policy provision. Welfare state policies and culture are mutually interrelated in a very complex way and sometimes also contradictory ways. It could also lead to a way of analysing the impact of Confucianism on East Asian Welfare regimes. Furthermore, the fabric of the Korean welfare system is determined by a number of ideological influences. The Confucian welfare legacy is, of course, dominated by Confucian ideology. Korean society has always emphasised a dependence on family rather than the state. The values underlying the Korean welfare system are an amalgam of traditional and contemporary ideologies. The Confucian welfare legacy of family dependence rather than government dependence has been promoted by the Korean governments as a means of lessening the welfare burden on the state.

9.2.3. Contributions to Theoretical Perspectives for Mental Health Policy Developments

In Chapter 3, a wide range of perspectives exploring mental health policy developments has been examined in terms of their relevance as the theoretical rationale for understanding Korean mental health policy developments: the humanitarian perspective represented by Jones, and the Marxist approach represented by Scull. None of these provides a satisfactory explanation for Korean mental health policy developments.

Foucault's early writings on mental health began quite close to the Marxian emphasis on social control (Foucault 1961; 1965). However, he diverged from Scull's analysis on two counts even at this stage. First, he puts the beginnings of segregation at an earlier point, the 'great confinement' of the mid-seventeenth to mid-eighteenth century. Scull argues that most of the mad were still roaming free in society at the beginning of the nineteenth century and it was not until the mid-nineteenth century that the state asylum system was well established to segregate madness. Second, Foucault emphasized the moral, not economic, order. Whereas Scull argued that psychiatry functioned to aid and abet economic efficiency, Foucault argued that psychiatry existed primarily to deal with those who offended bourgeois morality and rationality. For Foucault, segregative psychiatry was not concerned with either medical cure or economic efficiency *per se* but with moral regulation (Pilgrim and Rogers 1999, p.109).

Critical histories therefore challenge self-congratulatory versions of history, which tend to mask the interests of powerful sections of society, such as the psychiatric profession and the central capitalist State. However, Rothman (1983) suggests that there are problems with critical, as well as Whig, histories because in both accounts 'conception

triumphs over data'. According to Rothman, a focus on ideology, whether it is humanitarianism (Jones), capitalism (Scull) or surveillance (Foucault), can divert the historian's attention from the complex empirical reality of specific individual cases. For example, Scull's emphasis on the economic, Rothman claims, is overstated. The early American system of asylums appeared in the absence of a market economy. Ideas about madness, he suggests, can be influenced by idiosyncratic factors other than those associated with a capitalist mode of production (for example, ideals related to localised political activity and religious doctrine). (Pilgrim and Rogers, 1999)

This study has traced the development of policy initiatives that have directly and indirectly affected care of people with mental health problems since the 1960s. Also the study has examined some of the consequences of those policies, both intended and unintended, and pointed out how a concern about social order is a theme that can be commonly detected running through them.

Since the 1960s there has been an increased need for formal health and social services for those with mental health problems who have no informal carers. Despite the country's rapid demographic, economic and social changes, there has been a widening gap between the population's expectations and needs, and health and social service provision in the mental health arena. Neither long-term care services nor personal social services are well developed for those with long-term mental health problems. In addition there is a marked disparity between the acute services, which are predominantly provided by private sector organisations in a highly competitive market and broadly achieve high standards, and public primary care and rudimentary residential services in the mental health arena. In this context, it could be argued that Korean

mental health policy has been concerned with maintaining social order rather than care and treatment for those with mental health problems.

This study also found that one of features in Korean mental health developments is the emergence of the 'psy complex'. Mental health professions have been of particular interest to poststructuralists. Rogers and Pilgrim (1999, p.105) point about that the 'psy complex' has 'a chronic surveillance role in relation to mental patients'. They also present two types of discourse about the role of the 'psy complex': 'the first of these emphasised segregation and acting on the body (psychical treatments) and the second emphasised the construction of the self via a set of psychological accounts (counselling and psychotherapy) (Rogers and Pilgrim 1999, p.105). In this respect, it can hardly be denied that Korean mental health policy has not been concerned with either medical cure or economic efficiency *per se* but with segregative and surveillance apparatus for maintaining social order.

9.3. Towards 'Positive' Mental Health Services: Conclusion

While support for the principle of community care has been almost universal, community care policy has offered to the government the means of managing people with mental health problems and there is little sign that this will change. Thus, a range of in-patient treatment services are being developed, including secure hospital provision, psychiatric units in general hospitals, community mental health centres and a number of smaller initiatives. Treatment is also being made available in day hospitals, out-patient clinics, general practitioner clinics and other dispensaries, and by private office

psychiatrists. In this respect, a further set of issues that have arisen concerns the way in which service provision should be developed. Here this study intends to suggest 'positive' mental health services:

Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization, 1999).

In so doing, integrated mental health services should be developed.

9.3.1. Integrated Mental Health Services

Policy-makers can learn from the experiences of countries advanced in deinstitutionalisation in order to advance their own efforts in building a community-based mental health care system. Several principles of the implementation of comprehensive community-based services have been identified, including (a) an establishment of a single authority with responsibility for planning, implementing, and financing services; (b) consolidation of available funding sources for medical and social services; and (c) reallocation of human and financial resources from hospital to community-based programmes (MoHW, 2000).

In the framework of the Korean mental health care system, no core entity exists that can co-ordinate the psychiatric treatment, rehabilitative and social service needs of people with mental health problems and take the initiative in planning and implementing a comprehensive care system. 'Continuity of care' or 'service integration' will become a

concern as more and more people with serious and persistent mental health problems are treated in the community. An authority with responsibility for these activities is required to implement the goal articulated in the letter of the law.

An important problem in facilitating the system transition in Korea is the low cost of hospitalisation that provides little economic incentive to reduce the use of long-term inpatient care. The expenditures for involuntary hospitalisation subsidies have already gone down since the revision of the Mental Health Act in 2000. Given that the relatively high fee for ambulatory services might not reduce the cost significantly even within the health care system, not to mention the expected increase in social service cost, acquisition of new funding sources is needed to develop community support services in Korea rather than the redistribution of existing funding.

Furthermore, Korea is facing the problem of reorganising the private service delivery system. Private medical institutions are the major players in the mental health delivery system. The psychiatric hospitals have expanded their service boundary, providing residential and rehabilitative services as well as ambulatory psychiatric services. A question that needs to be examined is whether the medical institutions can design and implement services based on the philosophy of community integration of people with mental health problems, while redefining their role in the total system of care. To promote integrated mental health services some suggestions should be addressed:

- (a) Formulating policies designed to improve the mental health of populations;
- (b) Assuring universal access to appropriate and cost-effective services, including mental health promotion and prevention services;
- (c) Ensuring adequate care and protection of human rights for institutionalised patients with most severe mental health problems;

- (d) Assessment and monitoring of the mental health of communities, including vulnerable populations such as children, women and the elderly;
- (e) Promoting healthy lifestyles and reducing risk factors for mental and behavioural disorders, such as unstable family environments, abuse and civil unrest;
- (f) Supporting stable family life, social cohesion and human development;
- (g) Enhancing research into the causes of mental and behavioural disorders, the development of effective treatments, and the monitoring and evaluation of mental health system (WHO, 2001).

9.3.2. Getting an Early Start to Mental Health: Promoting mental health activities as part of public health services

In Korea, general health centres are more and more involved in mental health activities after the recommendation was made by the Ministry of Health and Welfare in January 2000. The recommendation asked general health centres in Korea to play a central administrative role to develop mental health programmes in the community. An average general health centre serves a population of around 100,000 to 150,000. One of the important programmes carried out at general health centres has been education for families of people with mental health problems. These developments at general health centres should be promoted as a positive step to promoting community-based mental health services in Korea.

9.3.3. Lifestyle Supporting Mental Health

The recent mental health and public health policies are directed towards the community integration of people with mental health problems. However, the Korean value system

regarding individual rights, responsibilities, and community attitude towards people with mental health problems is not congruent with accepting people with serious mental health problems as members of the society. In the community, people with mental health problems commonly face barriers in gaining access to housing and employment. Stigmatisation is a serious concern not only for affected individuals but also for their family members. The possible way to reduce stigma attached mental health problems will be to increase their treatment in the community. This could be realised through the introduction of a financing system favouring community care.

Furthermore, special programmes should be developed for most of the groups listed below as a positive step to promoting mental health services in terms of lifestyle supporting mental health in Korea:

- (a) People in need of long-term mental health care
- (b) Homeless people with severe mental health problems
- (c) People with drug abuse
- (d) Victims of sexual abuse or domestic violence
- (e) Children with mental health problems
- (f) Elderly people with mental health problems (e.g. dementia)

In more recent years the issue of population, however, has been attracting more and more attention in Korean policy planning. This attention is not so much related to the number of the people, however, but rather to the structure of it. That is, the 'problem' of ageing. Korea has seen a growth in the proportion of older people in its population, which has been much more rapid than that of many other comparative countries

Over the last 30 years, falling fertility and rising life expectancy rates have caused the

proportion of children in the population to fall and the proportion of the working-age population to rise. The proportion of the aged rose slightly. The result has been a sharp fall in the overall dependency ratio. The old age dependency ratio is still relatively low, ranging mostly between 8-9 per cent. However, this is projected to double over the next 20 years, reaching the current old age dependency ratio of OECD economies (1995), and to triple in 30 years, reaching about 26 per cent by 2030 – this is approaching the projected levels in Europe and Central Asia, and well above other developing regions.

Due to the rapid increase in the geriatric population, and changes in family structure, services for geriatric patients, particularly for senile dementia, have become the priority all over Korea. The government should develop the following activities:

- (a) Consultation on geriatric mental health: consultation activities with families with senile dementia at general health centres;
- (b) Financial support to geriatric care centres;
- (c) Training for general physicians and public health nurses in the management of senile dementia;
- (d) Support to the in-patients rehabilitation facilities for senile dementia patients;
- (e) Development of comprehensive community care systems for senile dementia including health, medical treatment and social rehabilitation.

9.3.4. Employment and Work

Supporting people with serious mental health problems to work in the competitive labour market remains a difficult task in Korea. However, in Western countries, there has been an underlying belief that ‘everyone ought to work to their capacity, both for their own benefit and in order to minimize their dependence on their nation’s

increasingly grudging generosity' (Baron 2000, p.375).

In this respect, the mental health system should acknowledge the importance of employment as a goal and the vocational rehabilitation system should focus on employment. Baron (2000) has presented a 'best case' scenario for promoting employment for people with mental health problems:

Public policies recognise the benefits – to the client, to their communities, and to national economies – of promoting economic independence for people with mental health problems. This would require consistent public policies that support work, substantial increases in funding for rehabilitation programming, the reformulation of medical insurance programmes that can continue to cover those with mental health problems even after they are hard at work, and the creation of job opportunities that are both flexible and sufficiently remunerative to motivate people to work (p.389).

9.3.5. Protection of Human Rights of People with Mental Health Problems

Regarding human rights and responsibilities, it is indicative that Korea has no specialised legal provision for criminal offenders with mental health problems. Criminal offenders acquitted because of insanity are treated in the same manner as any other involuntarily admitted patients. Treatment and discharge is carried out completely in accordance with the Mental Health Law and the criminal court will no longer intervene in the management of patients. The preference for custodial care of people with mental health problems is intertwined with Korean cultural and social characteristics.

The neglect of human rights of psychiatric patients has a long history in Korea. There have been reports of widespread abuse in mental hospitals and conditions in hospitals

reflect the custodial nature of the care provided. Although the Mental Health Act 1995 implemented protective measures and the majority of patients have been voluntarily hospitalised since then, nearly half of the voluntary patients are still treated in locked wards. Moreover, the effectiveness of psychiatric review boards has been questioned. For example, only a small number of appeals for discharge to psychiatric review boards were approved (7%) (Suh, 2000). Suh (2000) argued that psychiatric review boards tend to reject discharge of applicants unless they have a place to go to with their family's consent, even if they are clinically suitable for discharge. These issues were addressed in the revision of the Mental Health Act 1995, which required the Ministry of Health and Welfare to revise the guidelines regarding treatment of a voluntarily admitted patient in a locked ward and the psychiatric review board. It is too early to discuss practical implications of the most recent revision of the law at the time of the writing.

9.3.6. Empowering Users and Carers

The process of system transition is not likely to accelerate in the near future within the cultural, social, and political context. However, significant change is occurring as an increasing number of individuals with mental health problems are organising and speaking publicly via the mass media, and at symposiums, conferences, and fund raising events. Having people with mental health problems living in the community and listening to their voices may have the most significant impact on changing community attitude, enhancing understanding of the process of recovery from mental health problems, and improving the mental health care system. In order to develop 'positive mental health', users and their carers should be empowered and involved in the policy

making process.

Due to the strong stigma attached to mental health problems, the involvement of users in the planning and evaluation of mental health problems is still at a very early stage. The weakness of consumer involvement is based on a paternalistic cultural background. In Korea, 'good mental patients' are viewed as patients who obediently follow the instructions of doctors and nurses.

In addition, consumer participation needs more attention. In Western countries, especially in the USA, consumers have played an important role in the development of mental health care models (Salzer, 1999). Salzer (1999, p.75) has pointed out that 'the concerns and perspectives of mental health consumers are more frequently voiced and heard, and are influencing service delivery concepts and how services are evaluated'. However, in Korea, consumers' power and influence on the present services are far less pronounced. The Association of Families with Mental Patients runs an internet website for the education of family members on mental health problems, which is now used at health centres. Consumer involvement in mental health will be an important area to be promoted in Korea in the future.

9.3.7. Caring about Carers

Carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental health problems. Providing help, advice and services to carers can be one of best ways of helping people with mental health

problems.

While caring can be rewarding, the strains and responsibilities of caring also have an impact on carers' own psychological and physical health. These needs must be addressed as a positive step to promoting community-based mental health services in Korea. There has evolved a 10 Point Plan for Carers suggested by the Carers National Association in the U.K. This plan would be very helpful for promoting positive community mental health services:

- (a) Recognition of their contribution and of their own needs as individuals in their own right.
- (b) Services tailored to their individual circumstances, needs and views.
- (c) Services which reflect an awareness of differing racial, cultural and religious backgrounds.
- (d) Opportunities for a break, to relax and have time to themselves.
- (e) Practical help.
- (f) Someone to talk to about their own emotional needs.
- (g) Information about available benefits and services.
- (h) An income which covers the cost of caring.
- (i) Opportunities to explore alternatives to family care.
- (j) Services designed through consultations with carers, at all levels of policy and planning.

Furthermore, the legislation for caring about carers should be formulated to meet the needs of carers. For example, the Carers (Recognition and Services) Act 1995 in the U.K. gives carers who provide a substantial amount of care on a regular basis a right to assessment of their needs as carers. It is important that social workers bring this provision to the attention of carers, and that local authority eligibility criteria is designed with the needs of carers in mind.

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Appendix II: Informal Interview Questions

1. What first alerted the Government to the need to develop its mental health policies?
2. What was a prepared set of major alternative policies, including some 'good one'?
3. How did you identify, design and screen the alternatives?
4. Did you compare the predicted benefits and costs of the various alternatives and identifying the 'best' ones?
5. Did you evaluate the benefits and costs of the 'best' alternatives and deciding whether they are 'good' or 'not'?
6. Having identified that a problem existed can you please advise how the CMHC model came to be adopted?
7. Were other service models considered that were discounted?
8. How demands are advanced by stakeholders (such as Professional groups, Owners of mental sanatorium, Consumer groups, etc)?
9. What was the form of government involvement in policy-making – e.g. responding to initiatives from elsewhere or driving change?
10. What were the established operational goals, with some order of priority?
11. Were there any established sets of CMHC's significant values, with some order of priority?
12. Resources and constraints (the formulation of alternative policies or combinations of policies goes forward on the basis of resources available, and constraints upon choice)?
13. How did you allocate resource to CMHC initiatives and if so on what basis?
14. How did you predict the future environment on operation context?

Appendix III: Key Mental Health Policy Developments in South Korea

| Year | Key Developments |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1984 | - The First-ever Planning Report for Mental Health |
| 1986 | <ul style="list-style-type: none"> - Subsidiary Programme for Asylum - Survey of Treated Prevalence of Mental Health Hospital (I) |
| 1987 | - OECF Fund for Restructuring of Mental Hospitals |
| 1988 | - Survey of Treated Prevalence of Mental Illness (II) |
| 1994 | - Mental Health Policy Research |
| 1995 | <ul style="list-style-type: none"> - Task Force Committee of Mental Health Act Legislation - Insurance Coverage for Day Hospital - Enactment of Mental Health Act |
| 1997 | - Establishment of Division of Mental Health within the Ministry of Health and Welfare |
| 1999 | <ul style="list-style-type: none"> - Mental Health Facility Survey - Community Mental Health Project of Central Government |
| 2000 | <ul style="list-style-type: none"> - National Mental Health Delivery System Research - Technical Supporting Committee of CMH of Government - Standard Guideline of Community Mental Health Centre - 2nd Amended of Mental Health Act |

