

The Changing Shape of Care-time Diamond: Social Care Expansions in the 21st Century in Korea*

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Abstract

Traditionally, caring for young children and the elderly has been largely assumed and practiced intensively within the family in Korea. The Korean government established residual protection systems for the elderly as well as children whose needs could not be met by their family members alone. However, in the 21st century, a number of social forces have made it necessary to expand the state's intervention in the care provisions. The primary forces include the ageing process, low fertility, change in the women's labour market participation, changes in the family formation and dissolution, and changes in the people's perceptions of familial responsibilities regarding caring for other family members. This paper employs and further develops the idea of

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the care diamond conceived by the United Nations Research Institute for Social Development Project in relation to the political and social economy of care and applies it to Korea's social care expansions. The analysis demonstrates that the roles of the public and the market sector, in case of child care, increased while those of the third sector decreased. Apropos of the elderly care, the role of the market expanded dramatically, followed by that of and the state and the third sector. Nonetheless, it is important to note that the fundamental characteristics of Korea's care provision for children and the elderly have remained unchanged and even strengthened where the elderly care is concerned. The bulk of personal care demand is still met within the family, particularly by female members of the household.

Key words: child care, the elderly care, care diamond, care time, Korea

1. Introduction

Caring for young children and the elderly in Korea has been traditionally and strongly presumed and intensively practiced as a responsibility of the family. Relationships amongst family members and their roles were prescribed by the code of Confucianism and the ethics of filial duty. Parents and grandparents are the primary source of care-givers for their children. Grown-up children repay their parents by caring for them in their old age. But, in recent decades, demographics have shifted due to the ageing society and the low fertility rates. The total fertility rate decreased from 3.6 in the 1970s to 1.2 in the 2000s and the proportion of the elderly aged 65 and over increased from 4% in 1980 to 11.3% in 2010. It is also estimated to increase to 14.9% by 2019 and 20.8% by 2026 (An, 2010a). The family structure has also changed with regard to the family formation and dissolutions as well as living environments. In the 1980s, 45% of the total households had more than five members. This proportion plummeted to 24% in the 1990s and 10% in the 2000s. On the other hand, the proportion of households with one or two member increased from 18% in the 1980s to 27% in the 1990s and 42% in the 2000s.

Changes in the labour market have also occurred, resulted in increases in women's participation in paid work. Female labour market participation rates increased from 41.3% in the 1970s to 49.5% in the 2000s while those of men decreased from 77.5% to 74.1%. During the last four decades, the percentage of male paid workers rose from 47.5% to 66.1%. The proportion of female paid workers also drastically increased from 31.4% to 66.4% (An, 2010a). In this light, expanding child care reform ultimately resulted from the need to address the low fertility and fulfil the increasing social demand or desire for women to live longer than the old generations as workers. As a result of these changes, it quickly became evident that the past practices in care provision were no longer sustainable. This has made it necessary for the government to assume a greater role in care provisions.

Since the 1990s, the Korean government has taken on a larger role in regulating, providing, and financing social care services (Peng, 2009). The state provision for child care was defined via the Child Care Act reformed in 2004 and the Saeromaji initiative (2006-2010), the first low-fertility and ageing society plan. In the case of the elderly care, the state introduced the Long-term Care Insurance (LCI) programme in 2008. Scholars recently analysed how the government's interventions have influenced the institutional arrangements of care in Korea. The United Nation's Research Institute for Social Development, focused on the political and social economy of care, has spearheaded such discussions, and the author participated in the Korean case.

This paper employs the care diamond with a view towards examining the reconfiguration of care provisions amongst the state, market, third sector, and family, but makes an initial attempt to turn the discussions from a qualitative approach to a quantitative one. The analysis shows that the state's intervention has expanded the roles of the state and the market while reducing those of the third sector in the case of child care. *Vis-à-vis* the elderly care, the role of the market has expanded dramatically, followed by the state and the third sector. Nonetheless, it is important to note that the fundamental characteristics of Korea's care provision for children and the elderly remain unchanged. The bulk of personal care demand is still coped with within the family, particularly by female members of the household.

This paper is organised as follow: the first section discusses child and elder care expansions in the 2000s, which is followed by the discussions the care-time diamond as an approach for quantitative understandings for the institutional arrangements; the third section discusses methodology of how to develop the care-time diamond; the fourth section discusses the results.

2. Child and elder care expansions

In the history of the Korean welfare state, the 2000s marked the second phase of noticeable changes¹⁾. Even though the care policies for children and the frail elderly were parts of welfare expansions during the first centre-left government of Kim Dae Jung (1998-2002), it was under the second centre-left administration of Rho Moo Hyun (2003-2007) that it became the key domain of the welfare expansions. In order to examine the reconfiguration of care provisions, it is necessary to understand the policies that can impact individual behaviours related to care practice. These policies run the whole gamut of areas from labour market to work and family reconciliation. In the arena of social care services for the children and the frail elderly, there are care facilities, kindergartens, after-school care programmes, private schools (*hak-wons*), and vouchers. However, for the reasons that follow, the discussions on the care expansions focus on the care facilities and kindergartens for child care and the care facilities for the frail elderly. Firstly, the paper focuss on care facilities for pre-school children. Secondly, the *hak-wons* offers care for preschool children, but complete data are not available to discern how the child care provisions through the *hak-won* systems have been reconfigured in the institutional arrangements. Likewise, the voucher programmes for

¹⁾ The first occurred during the first centre-left government of Kim Dae Jung (1998-2002) after the recession that swept through Asia in 1997. The reforms were made largely in the arena of social insurance policies and public assistance programmes. The National Pension System became a universal programme, with its coverage expanded to include the self-employed in urban areas. Kim (2008) described it as evidence of Korea's welfare state becoming a universal welfare regime. In addition, the livelihood protection programme introduced in the 1970s transformed its nature into a right-based programme in 2000. The labour policy was also reformed to become more inclusive.

the elderly should be important but data is not available. It is important to note that the care facilities for pre-school children including kindergarten and care facilities for the frail elderly are the major parts of the care service provisions. The scope of this paper is therefore limited to the analysis and the discussions of the policy expansions to the child care and elder care facilities

1) Child care facilities

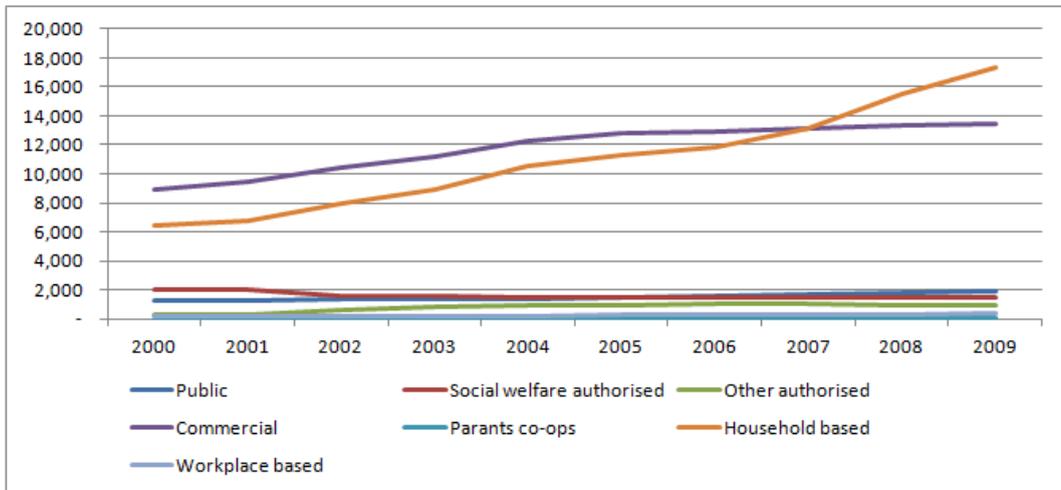
The Child Care Act (CCA) introduced in 1991 facilitated the development of both public and private child care centres. Its revision of the CCA since 1990 included a certification system of child care centres, a child-care information centre, expansion of child-care expenses support for 5-year-old children, and a sliding scale system of child-care benefits. The sliding scale system of child care is designed to expand the benefits to include families with an income of 130% of the minimum costs of livings (poverty line) while providing different levels of child care fees based upon the families' income levels. It also introduced child care fee support for families with five-year-old children. Remarkable changes were made through the first low-fertility and ageing society (Saeromaji initiative, 2006–2010). It first expanded the beneficiaries of child-care expenses support for children between aged 0 and 4 to families with less than 50% of the average income. Second, it expanded the beneficiaries of child-care expenses support for 5-year-olds to households with income that fell below 100% of paid workers' average incomes. Third, it introduced child-care expenses support for families with more than two children. Finally, it introduced a child-care allowances for children aged between 0 and 1 who are not registered with child-care facilities.

The state intervention increased drastically in terms of the budget for child care from 28,396 million KRW in 1991 to 600,091 in 2005 and 21,275,510 in 2010. In terms of GDP, this amount accounted for a mere 0.1% in 1991, but increased to 0.7% in 2005 and 1.8% in 2010 (Ministry of Health and Welfare, 2012). There are seven types of child-care facilities. The first is public facilities and they are those set up and managed by central and local gov-

ernment (including those that are contracted out). The second is social welfare corporate bodies and they are non-profit. The third is corporate bodies in other areas, which are also non-profit facilities. The fourth is commercial facilities run by individuals. The fifth is parent co-ops managed by more than 15 parents. The sixth is household based facilities which are established by individuals and the last is workplace-based facilities.

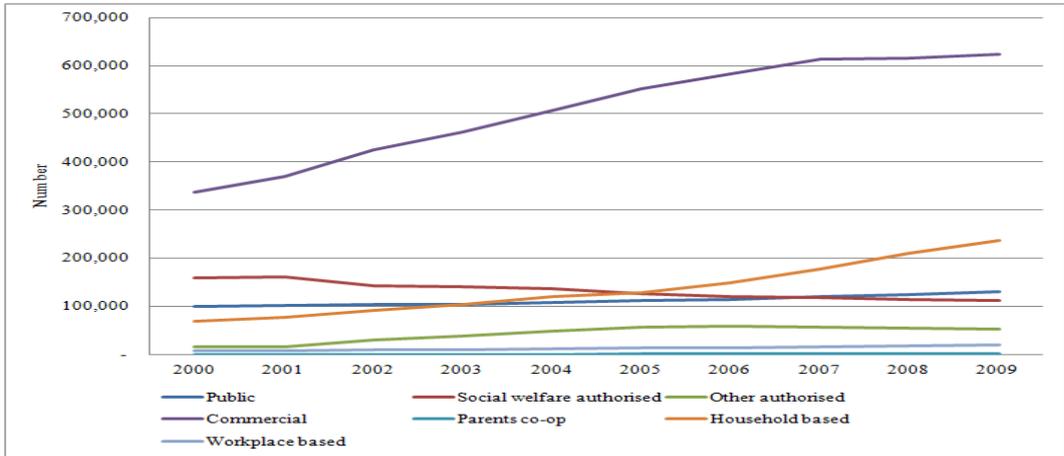
Figure 1 shows the number of child care facilities established between 2000-2009. Total number of facilities increased by 1.8 times between 2000 and 2009. The public accounted for 6.7% of total facilities in 2000 and the ratio decreased to 5.5% in 2009. The increase in the first half period of the 2000s is featured with the increase of commercial facilities: an increase by 1.4 times. On the other hand, the second half is features with the development of household based facilities which increased by 65%. In addition, the number of children at these facilities in 2009 (1,175,049) increased by 1.7 times higher than that of 2000 (686,000). Substantial increase occurred in household based facilities, by 28.6 times (Figure 2).

Figure 1. Child Care Facilities



Source: Ministry of Health and Welfare (2010a)

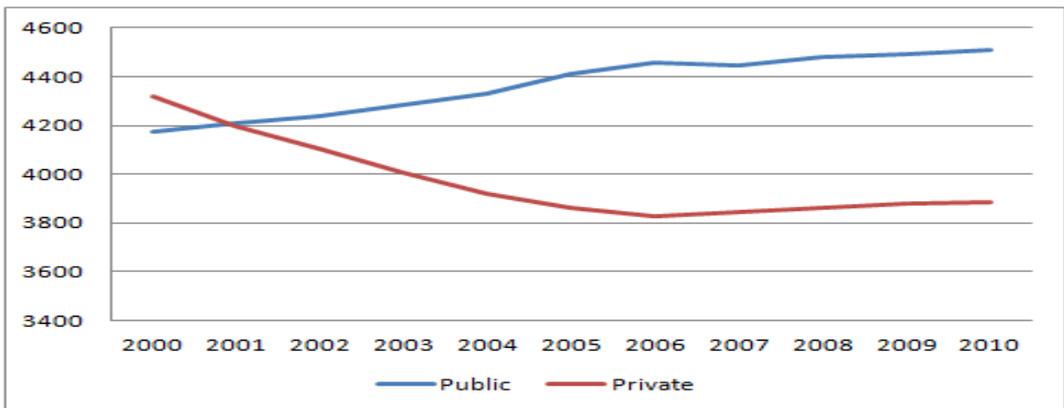
Figure 2. Children at Child Care Facilities



Source: Ministry of Health and Welfare (2010a)

Kindergartens in Korea are divided into either public or private. In addition, the number of public kindergarten also increased from 4,325 in 2004 to 4,493 in 2009 while that of private kindergarten decreased from 3,918 to 3,880 (Figure 3). The number of children at the public kindergarten increased from 123,906 in 2004 to 125,536, in 2009 while that of private kindergarten decreased from 417,807 to 411,825 (Ministry of Education, Science and Technology & Korean Educational Development Institute, 2005, 2010)

Figure 3. Public and Private Kindergartens



Source: Ministry of Education, Science and Technology & Korean Educational Development Institute (2005, 2010)

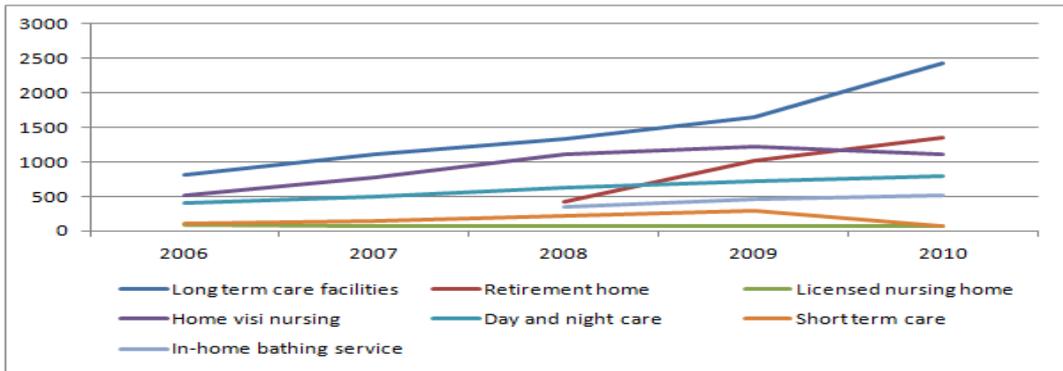
2) Care facilities for the frail elderly

The LCI was introduced in 2008 aimed to provide the elderly aged 65 or older who are dependent on others for help with the requirements of everyday living. The LCI includes in-home services, institutional services, and cash benefits²⁾. The institutional services include: 1) long-term care facilities; 2) licensed nursing homes and; 3) retirement homes. The range of in-home services covers: 1) home-visit nursing; 2) day and night care; 3) short-term respite care and; 4) home-visit bathing services via a vehicle equipped with a portable bath to provide the service at home.

The government budget increased remarkably. Social expenditures for the frail elderly were 300 million KRW in 2002; this amount increased to 255,500 million in 2008 and 447,526 million in 2010. In 2007, the percentage of the budget for the elderly compared to the GDP was only 0.58%. This ratio increased more than three times, reaching over 2% of the GDP in 2008. In addition, the elderly care facilities increased dramatically, by 1.5 times in 2008 alone and continued to increase by 27% in 2009 and 22% in 2010. The phenomenon is largely attributed to the increase of long-term care facilities, retirement homes, and home-visit nursing (Figure 4). The number of the elderly using the facilities has also increased drastically. In the case of long-term care facilities and retirement homes, the number of individuals helped increased by nearly three times between 2005 and 2009. The number of the elderly receiving care at licensed nursing homes increased by 1.8 times during the same period. Users of the home visiting services increased substantially as well, from 32,000 to 122,418, while users of day and night care services increased from 5,226 to 26,088 (Figure 5)

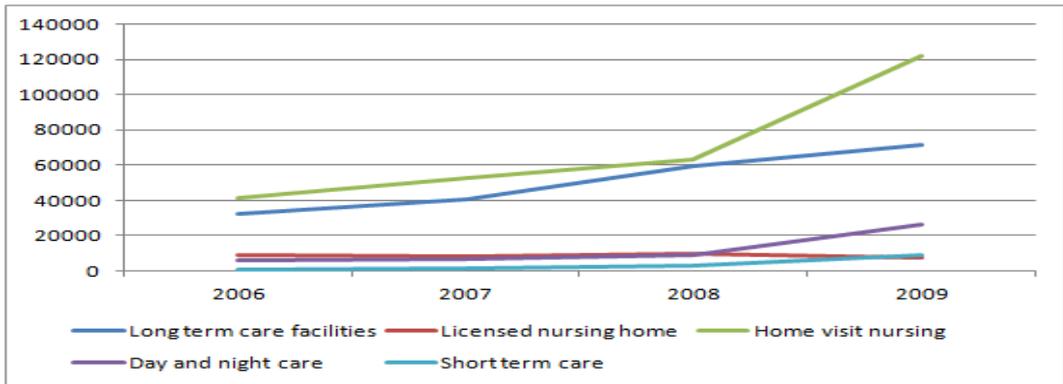
²⁾ Cash benefits are designed to help the elderly and their families pay for the costs of health care when the beneficiary lives in a remote region or in one of the country's islands, which have few facilities for long-term care. They are also given to persons who need care but whose physical, mental, or psychological condition makes them unsuitable for admission to a long-term care establishment. They can also be used to meet part of the cost of long-term care provided at home or in an institution by a non-registered service provider. This partial coverage of costs may also apply to lengthy periods of residence in geriatric care facilities.

Figure 4. Elderly Care Facilities



Source: National Health Insurance Corporation (2010)

Figure 5. The Elderly Received Care Services



Source: Ministry of Health and Welfare (2007, 2008, 2009a, 2010b)

3. Care-time diamond: seeking a quantitative understandings

The political economy of care provisions by and amongst the different sectors is examined at the macro-level of analysis (Evers & Svetlik, 1993; Daly & Lewis, 2005). The institutional arrangements and re-configurations have long been key issues in welfare regime analysts' dialogue. A number of terminologies have been put forth, including welfare regime, the welfare diamond, and the welfare triangle. At its core, these terms refer to the arrangements fo-

cusing on where the welfare is produced, namely, the supply side. The state is not only a provider, but also serve as influencing the distribution of the responsibility assumed by the other side of welfare providers.

For the second phase of welfare expansions under the Rho administration where care for children and the frail elderly became buzz words, the dialogue however has not yet been fully developed to discuss how the social care expansion affected the paradigm of the Korean welfare regime. Peng (2011) argued that the ideational approach shifted from a productive welfare to social investment through social care expansions; this shift was based upon human capital and economic activation perspectives (Peng, 2011: 41). Seok (2008) argued for the enhancement of the government's role as a regulator in the care provisions for the frail elderly in order to minimize the market failure in the service delivery.

The leading analysis on the institutional arrangements with regard to the Korean social care expansions has been conducted by the United Nations Research Institute for Social Development (UNRISD, 2007-2009), in which the author participated for the Korean case. This project expedited the development of social care research in East Asia by Ochiai (2008, 2009), in Japan by Abe (2010), and a special edited volume of the *Journal of Comparative Social Welfare* in 2011. The UNRISD project employed the care diamond, developed by Razavi (2007), as a conceptual framework. The institutions involved in care provisions were reconceptualised into the public, market, family/households, and the not-for-profit sector, the four components of the care diamond. As for Korea, Peng (2009) pointed out that the role of the market is likely to increase in the care diamond. NGOs and volunteering organisations will play a larger role, while the family will continue to be an important site of social welfare and care, although some of its care responsibilities will be alleviated due to the expanded participation of the state and the market. Baek et al (2011) observed that a shift has occurred to the socialisation of care through the vitalisation of markets. However, despite such changes, the onus of care is still on families. In Japan, Abe (2010) argued that the elderly care is still strongly dependent upon family. Ochiai (2009) maintained that the most prevalent pattern involves a large family and relative sector as well as a large market sector

for East Asian and South-East Asian countries.

These analyses have arrived at their respective conclusions using qualitative practices; consistent analytical tools across the elderly and child care and different countries were not fully developed to draw the diamond. Rather, these analyses focus mainly on characteristics of the elderly and child-care policy from the standpoint of which sector finances, manages, and regulates the benefits. As such, the UNRISD project failed to develop a quantitative measurement to compare the role or function of the market, state, not-for-profit sector and family in its configuration with policy changes. It only succeeded in analysing the time spent within family on the elderly and child care (An, 2008, 2010b), revealing significant gender differences in time spent on paid and unpaid care work. The diamonds were drawn in Ochiai's (2009) and Abe's (2010) analyses, but the drawings are inferences. Abe (2010) asserted that the roles of the market and the state overlap nearly completely in terms of the elderly care as the market works through the state. On the other hand, the market is clearly separated from the state in child care. The diamonds presented (Abe, 2010; 38-39) do not support the argument that the family is still the primary source of care provisions as the size of the circle, which straddles the four vertexes of the diamond, is apparently very similar. Furthermore, the analysis did not encompass the role of the community; instead, the sector was included as part of market provisions. In addition, different sources of data were utilised for the child care and the elderly care diamonds. The number of people who require some care and the professional care recipients were used for the elderly care diamond while the number of facilities was used for child care diamond. Ochiai's (2009) analysis of the care diamond in East and South-East Asia does not explain how she drew them.

Looking into the changes in the shape of the care diamond in the Korean context, we operationalise the care discussions from the macro- to the micro-level of analysis. According to Jensen (1997), three questions - who cares? who pays? where is care provided? - frame a care-centered typology of social policy. The first question is directly related to gender as it ascertains whether the care provisions are the collectivity or the family. Whether it is both parents or only mothers is also relevant. The second question is related to the dis-

tribution and redistribution of cost. The last is where the non-familial child care or elder care is provided through public services or through the markets which either could be non-profit as well as for-profit care-givers.

The notion of the welfare diamond has merits as it adds voluntary provisions which are the heterogeneous clusters of care providers to the welfare triangle (Esping-Andersen, 2002) of state, market and family (Razavi, 2007; 21). Charitable, religious and community-based organisations have long been important care providers (Anttonen, 2005). Ochiai (2009) argues for the separation of community/voluntary sector provisions from the market provisions for profits as it is the key dimension in the East Asian care regime. Hence, this paper examines the configuration of the state, market, family and the third sector which includes voluntary and community provisions. The third sector refers to the range of organizations that are neither public sector nor private sector. It includes voluntary and community organisations both registered charities and other organisations such as associations, self-help groups and community groups, social enterprises, mutuals and co-operatives. The key question is where care is provided and how much it has changed. The welfare and care diamond approaches have their own limitations in that the institutional arrangements amongst the state, market, third sector, and family are hardly mutually exclusive. For example, as Razavi (2007) pointed out, the market provision is rarely pure as the state often subsidises and regulates market providers. Nonetheless, this approach is attractive to welfare states in East Asia, where the family has long taken the exclusive role in care provision.

How is the question of "where care is provided" operationalised? So far, the theoretical discourses on comparative care regime (Daly, 2002; Morgan & Zippel, 2003; Daly & Lewis, 2005) have put weight on how care labour, responsibilities, and costs are distributed and redistributed via policy changes amongst the family, the market, the state, and the voluntary/community sectors. It is worthwhile to compare the details of policy contents and structures. However, the labour, cost and responsibilities are not separate issues when it comes to the care practices. As Gornick & Meyers (2003) assert, parents do not perceive the policies individually and their decisions are influenced by a package of policies.

Care diamond is not only useful for social and political economy of care. It is also useful for comparative analysis of how much care is practiced in the institutional arrangements. So far, the relationship between policies and time spent on care work has rarely drawn scholarly attention. Among the few, Sayer et al (2004) find that some cross-national differences and similarities in child care practices measured in terms of time could be related to family policies. Sullivan et al (2009) argue that the availability, cost and quality of child care influence the ways in which parents use or do not use leave and other policies. Indeed, the complex interplay of incentives and availabilities of care provisions influence the couples' decisions about where their children and frail parents are cared for, apart from home and even the allocation of time between paid and unpaid work.

4. Methodology

Vis-à-vis the care-time volume within the family, we analyse the time use survey. The National Statistics Office has been conducting its Time Use Survey (TUS) every five years since 1999 with the aim of collecting information on how people spend their time during a 24-hour period. The current study uses the 2004 and 2009 TUS data. Both the 2004 and 2009 survey contained household and individual questionnaires, thus, the instrument consisted of three parts: the household questionnaire, the individual questionnaire for respondents ten years of age and older, and the time diary. The household questionnaire collected data on household characteristics, including the type of occupancy, dwellings, floor space, and vehicle ownership. The individual questionnaire collected data on individual characteristics, including relationships with the head of household, gender, age, care for infant children, feelings about time pressures, the gender role, economic activities, side jobs, weekly work time, industry, occupation, employment status, monthly average income, days off, and subjective evaluation of time pressure and tiredness. In the time diary, all household

members aged ten years and older were asked to record the main and simultaneous activities structured in ten-minute intervals for the two designated days. All the self-recorded activities in the time diary were coded into three-digit activity codes, which were divided into nine broad categories including personal care activities, employment, study, household maintenance, family care, voluntary service, leisure, travel, to name a few.

It includes both main and simultaneous activities from those who indicated their participation in the care activities for pre-school children and the elderly. For the child care, the analysis includes such activities as physical care, help with reading and studying, playing, and nursing care. TUS also collected information on care for spouse, parents, and other family members, with care activities being categorized as either nursing care or other care. We include time for nursing care as the analysis considers the frail elderly alone.

In order to calculate the child-care time spent in the four sectors, we first re-categorize the child-care facilities into state, market, and the third sector. Issues of subsidies, regulations and ownerships between the three sectors are always complex and are not mutually exclusive. However, it is useful to differentiate the public provisions from the market provisions and likewise between market provisions by private individuals and those which are community and voluntary based. Thus, the classification in this research is based on the establishment and running body of the care facilities. Among the seven types of child care facilities, we regard the public as state provisions, and deem social welfare corporate bodies, other corporate bodies and parents co-ops as the third sector provisions. Finally, we include commercial facilities, individual run household based, and workplace-based facilities as market provisions. In addition, we include public kindergartens as state provisions and private kindergartens as market provisions.

The Ministry of Health and Welfare published a list of all the elderly care facilities, including the number of recipients registered. Based upon the body of the establishment of the care facilities, we divided them into state establishments, private establishments for profits, private establishments for non-profits, religious based, and civil society organisation

based. We consider the state establishments as state provisions, private establishments for profits as market provisions, and non-profit private establishments, religious based and civil society organisation based as third sector. In fact, when it was not clear, we contacted them directly for verification.

In order to calculate the care time volume, we used the number of care workers of facilities and teachers at the kindergartens and the average working hours. The Korean government provides data on the average working hours of child care workers that differ according to the type of facilities. However, it does not do the same for the elderly care. Therefore, we alternatively use a single count of average working hours. Table 1 summarises the number of workers and average working hours for both child and the elderly care in 2004 and 2009.

Table 1. Number of Child Care and the Elderly Care Workers and Working Hours in 2004 and 2009 (hours:minutes, a day)

	Child care				The elderly care			
	2004		2009		2004		2009	
	Average working hours	Number of workers						
State	9:29	17,662	10:00	28,020	7:05	1,741	7:05	2,467
Market	10:48	111,117	13:08	188,924	7:05	2,975	7:05	32,789
Third sector	10:24	27,315	9:09	25,378	7:05	26,444	7:05	44,025

Note: The number of workers for child care and the working hours include those at kindergartens.

Source: Ministry of Health and Welfare (2004, 2009a, 2009b), Kim et al (2011)

5. Results and discussions

1) Growth of the market sector in both child and the elderly care

The child care expansion in Korea in the 21st century is characterised by the growth of market provisions, followed by state provisions. Market provisions between 2000 and 2009 increased by 2.6 times and the state provisions increased by 1.5 times. On the other hand, the third sector increased relatively less (Figure 6). Figure 7 shows the trends of the state, market, and the third sector provisions for the elderly care. Between 2005 and 2009, the third sector was responsible for the largest provisions. In terms of the volume of the increase, state facilities increased from 55 to 128 (232%). The number of market provisions increased from 243 to 2,554 (1051%) while the third sector provisions increased from 1,122 to 2,737 (244%). Therefore, in both child and the elderly care, policy reforms have resulted in improvements in the function of market, the state, and the third sector in that order.

Figure 6. Child Care Facilities, State, Market, and Third Sector 2000–2009

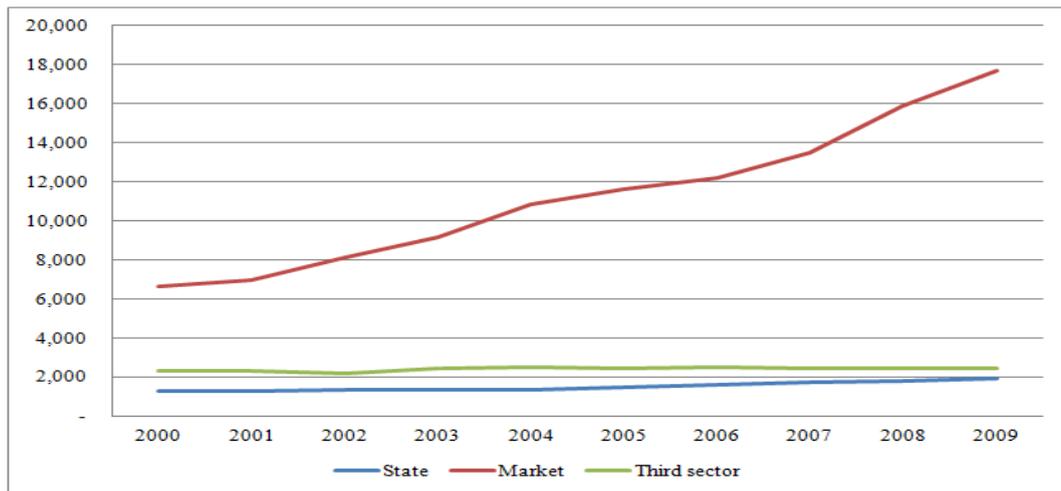
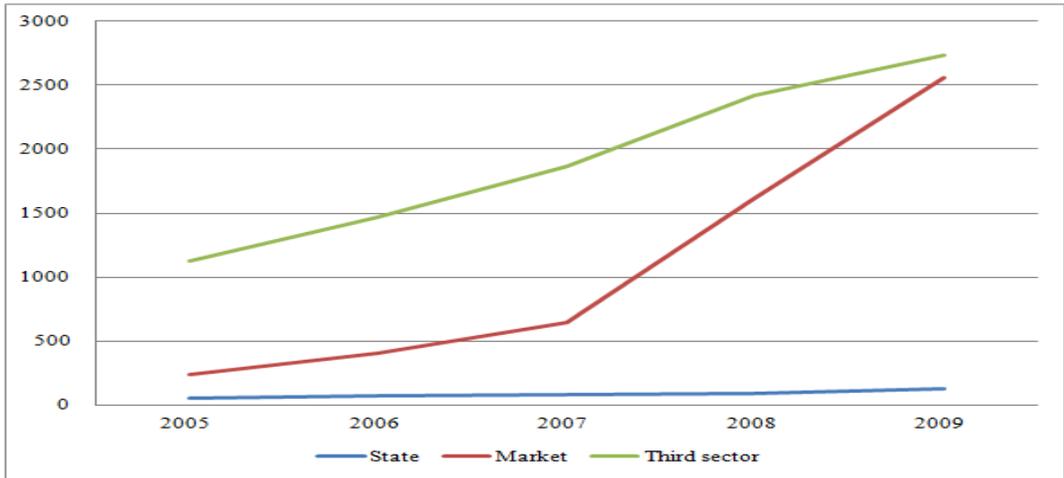


Figure 7. Elderly Care Facilities, State, Market and Third Sector 2005–2009



2) Care time volume

(1) Family

Tables 2 and 3 show the time spent on care activities for children and the number of participants in 2004 and 2009. The gender differences in caring for children were significant. In 2004, 2,283,727 men participated in some form of child-care activities while 7,048,717 women participated in such activities. The amounts of time spent differed as men spent 42 minutes per day on average while women spent 64 minutes. In 2009, the gender differences in time spent and the number of participants remained unchanged. The number of female participants in either main or simultaneous activities was more than twice larger than the number of their male counterparts. The average time spent by male participants on all child care activities amounted to 44 minutes per day while that of female counterparts reached 67 minutes.

Table 2. Time Spent on Child Care and Participants in 2004 (hours/numbers, a day)

	Male		Female		Total (hours)
	Time	Participants	Time	Participants	
Physical care	00:41	699,520	1:34	3,137,411	5,393,282
Aid with reading, studying & playing	1:00	1,378,466	1:30	2,468,097	5,080,612
Nursing care	00:36	41,148	00:39	292,825	215,025
Others	00:29	164,593	00:32	1,150,384	693,091
Total	1,960,713		9,421,297		11,382,010

Table 3. Time Spent on Child Care and Participants in 2009 (hours/numbers, a day)

	Male		Female		Total (hours)
	Time	Participants	Time	Participants	
Physical care	00:48	967,665	1:54	2,759,994	6,018,120
Aid with reading & studying	00:36	236,126	00:46	1,183,098	1,048,718
Playing	00:56	1,228,826	1:13	1,759,768	3,287,955
Nursing care	00:39	85,736	00:47	267,787	265,494
Others	00:43	383,395	00:55	1,432,928	1,588,283
Total	2,393,207		9,815,365		12,208,570

Tables 4 and 5 demonstrate the average time participants spent on the elderly care activities in 2004 and 2009, respectively. The gender differences were significant in terms of time and the number of participants. In 2004, 164,592 males and 313,742 females participated in the elderly care. Women's time spent on the elderly care accounted for 61% of all time spent on the elderly care. In 2009, the gender differences remained unchanged. The number of male participants was only 56% of female counterparts.

Table 4. Time Spent on Elderly Care and Participants in 2004 (hours/numbers, a day)

	Male		Female		Total (hours)
	Time	Participants	Time	Participants	
Nursing for spouse	1:40	82,296	1:11	125,497	285,665
Nursing for parents	1:36	82,296	1:23	146,413	334,212
Nursing for other family	-	-	1:51	41,832	77,389
Total		268,833		428,433	672,266

Table 5. Time Spent on Elderly Care and Participants in 2009 (hours/numbers, a day)

	Male		Female		Total (hours)
	Time	Participants	Time	Participants	
Nursing for spouse	1:14	127,403	1:18	180,845	392,229
Nursing for parents	1:21	88,359	1:57	162,085	435,351
Nursing for other family	1:14	17,139	1:13	69,530	105,733
Total		297,554		635,759	933,313

(2) State, market, and the third sector

Table 6 demonstrates that the child care provided by the state increased by 1.6 times in volume, from 109,360 hours a day to 176,513 hours a day, between 2004 and 2009. Child care provided by the market increased by 1.6 times between 2004 and 2009. Meanwhile, child-care time in the third sector decreased from 284,076 hours a day to 229,025. Similar changes occurred in the elderly care, increasing by 1.4 times in the state sector, 11 times in the market sector, and 1.7 times in the third sector between 2004 and 2009.

Table 6. Child and the Elderly Care Volume: State, Market and Third Sector (hours, per day)

	Child care		Elder care	
	2004	2009	2004	2009
State	169,894	266,192	12,332	17,475
Market	1,159,139	1,927,571	21,073	232,255
Third sector	284,076	232,209	187,312	311,843

6. Conclusions: market and state improvements and family remained the primary source

Figures 8 and 9 show the care-time diamond of child care and the elderly care in 2004 and 2009. This analysis indicates three important findings. First, the 2004 policy reform and the Saeromaji initiative substantially strengthened the role and function of the market sector in both child and the elderly care. The market function increased by 148% for child care between 2004 and 2009 and it increased by a dramatic 1,102% for elder care. Second, it also increased the function of the state both for the child and elder care: by 144% for child care and by 133% for elder care. Third, the care diamonds present different configurations for child and the elder care. The market and state are the primary providers in child care. For the elder care, the third sector and the market are the main providers. However it is noteworthy that it may only be a matter of time before the market provisions for the elderly care exceeds the third sector provisions.

Figure 8. Child Care–time Diamond 2004, 2009

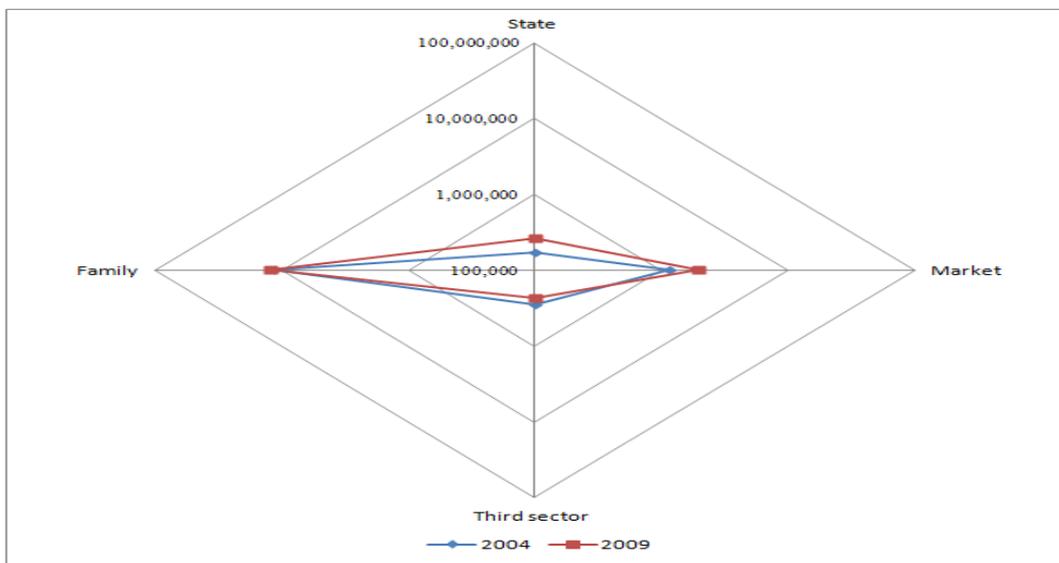
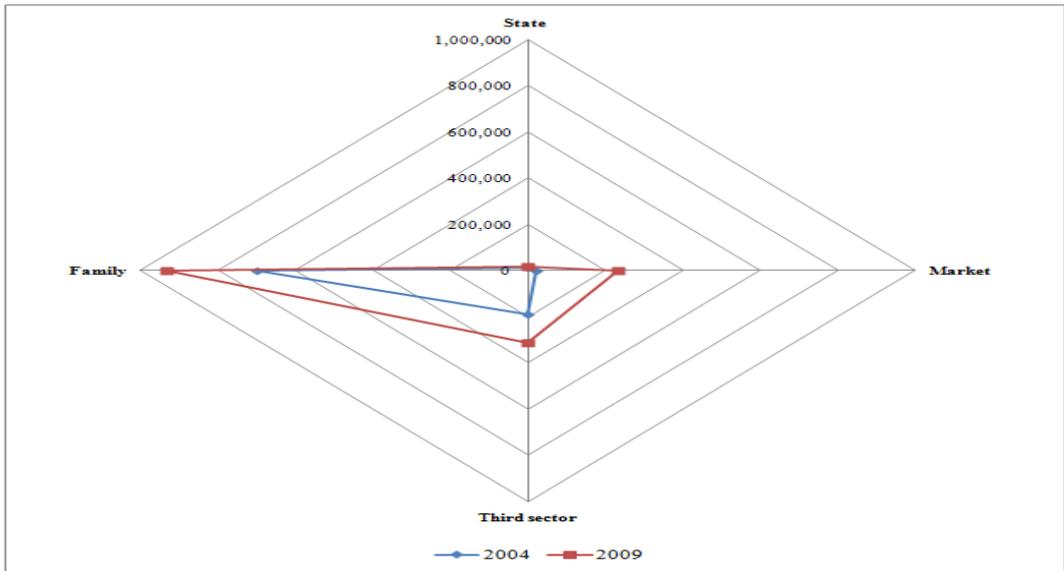


Figure 9. Elderly Care-time Diamond 2004, 2009



To what extent did the improvements in the state, market and third sector care provisions take over the familial practice? Does this mean that the configuration of the Korean care diamond has shifted from a strong emphasis on the family to a more balanced redistribution of care? The proportional share of care-time by the non-familial sectors against familial care time increased from 14% in 2004 to 20% in 2009 in child care and from 32% to 60% in elderly care. Therefore, vigorous state intervention resulted in some de-familisation. In the case of elder care, it is particularly noticeable. However, it is interesting to note that time that families spent in both child and elder care increased: the elder care by 26% and the child care by 7%. It may have something to do with demographic and social changes, and with changes in norms of child and elder care. The non-familial care time consists of 12% of total child care time in 2004 and the proportion rose to 17% in 2009. For elder care, it was 24% and rose to 37.5%. It indicates that the role and function of the family as the primary source of child and the elderly care provision have remained unchanged. It is important to note that only 41.4% of all children under the age of 5 received care from someone other than family members in 2008 (Ministry of Health and Welfare, 2009b). In 2010, amongst the

applicants to the NCI, 337,586 (88%) received these services (National Health Insurance Corporation, 2010). This figure is equivalent to 6.2% of the all elderly aged 65 and over.

This paper has shown how the Korean government's increased interventions in socializing care resulted in the reconfiguration in care provisions between the state, market, family and the third sector. It has also articulately shown how the institutional arrangements in care provisions can be quantitatively understood. There is considerable scope for future investigation regarding the institutional arrangements using care diamond. In particular, a fruitful avenue for future research may be to investigate the care diamond in East Asian and European welfare states.

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변화하는 케어-타임 다이아몬드: 한국의 21세기 사회적 돌봄의 확대*

안 미 영**

전통적으로 아동과 노인의 돌봄은 가족의 책임으로 여겨지고 관행적으로 실천되어 왔다. 한국정부는 가족에 의해서 돌봄을 받지 못하는 아동과 노인에 국한된 잔여적 제도를 구축해 왔다. 그러나 21세기에 들어서 고령화, 저출산, 여성의 노동시장 참여 증가, 가족의 형성과 해체의 변화, 가족 내의 돌봄 제공에 대한 인식 변화 등의 사회적 변인들은 돌봄 제공에 있어서 국가의 개입의 필요성 형성의 주요한 요인들로 작용해왔다. 이 논문은 유엔사회개발연구소의 돌봄의 정치사회경제학 연구에서 개발된 케어 다이아몬드 개념을 적용하여 한국의 사회적 돌봄 정책 발전을 국가, 시장, 가족, 제3의 부문 간의 제도적 분배의 변화를 분석하고자 한다. 분석 결과, 아동 돌봄의 경우, 정부와 시장의 역할이 증대된 반면, 제3의 부문의 역할은 줄었다. 노인 돌봄의 경우, 정부, 시장, 제3의 부문의 개입의 성장을 보였다. 그러나 한국의 가족 중심의, 특히 여성에 의한, 돌봄 제공 원칙은 변화하지 않았다.

주제어: 아동 돌봄 정책, 노인 돌봄 정책, 케어 다이아몬드, 돌봄 시간, 한국

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