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THE ELDERLY POPULATION IN KOREA: THEIR HEALTH STATUS AND KIN-BASED SOCIAL SUPPORT*

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The recent social concern about the elderly's life in Korea revolves around the gradual decline of the extended family as the prime institution for supporting the elderly. However, the results of my in-depth analysis of the Korean elderly's mental and physical health as well as the minimal social security mechanisms for the aged population signal that most Korean elderly still turn to their families for both instrumental and affectional support. The sustained importance of kin support under rapid socioeconomic modernization not only differentiates the Korean situation from the Western experience but also suggests a different way of coping with the growing aged population.

INTRODUCTION

Amid rapid economic growth and social change, Korean elderly people have been subjected to various patterns of new life situations which require both social and individual adaptation efforts. Demographically, the growth rate of the elderly population far exceeded that of the total population, and the proportion of the elderly population among the total population grew from 3.3 percent in 1970 to 3.9 percent in 1980 (Economic Planning Board (EPB) 1971, 1981) to 5.1 percent in 1990 (National Statistical Office (NSO) 1991). The same proportion will continue to increase, and one out of every ten Koreans will be elderly approximately by 2010 (Korea Institute for Consumer Protection (KICP) 1991).

In addition to such demographic changes, the quality of elderly people's life has also been significantly affected. Their physical health is of course an

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essential concern. In addition, the mental well being of the elderly has been threatened by new life patterns and different bases for social relationships. For instance, the National Institute for Psychiatric Treatment reported that the number of aged psychiatric patients has abruptly increased since 1975 (Kim, C. 1982). The senile psychoses causing such an increase include organic brain disorders, alcoholism, and chronic depression. A noticeable characteristic shared by the aged mentally ill was that they had commonly experienced stressful life events closely related to the modern way of life. Dissolution of the traditional inclusive relations is deemed the most critical aspect of such experiences (Kim, C. 1982). Since industrialization tends to induce a family system suitable for non-familial economic activities (vis-à-vis inclusive social support for family members), the aged gradually face unfavorable circumstances for satisfying various social and physical needs. Due to the prospect of diminishing social support, the mental well-being of the aged has become a serious social concern in Korea, in particular because the proportion and size of the aged population has rapidly grown (Kim, C. 1982; Lee, J. *et al.* 1984).

These social concerns will be addressed in this paper by examining the current socio-demographic profile, social support status and mental and physical health status of the elderly in Korea. Let me first describe some of the key parameters regarding the status and conditions of the Korean elderly in terms of demographic and social status, economic well-being, support from family, relationship with friends, and physical and mental health status. Secondly, I present the causal relationship between health status and social support of the aged with an analytical focus on the so-called "buffering effect" of social support against the stressful life situations (such as physical illness). And, finally, I discuss some policy implications concerning the welfare programs for the elderly in Korea. In this increasingly affluent society, the elderly's welfare will be meaningfully analyzed only when sufficient attention is paid to the actual subjective consequences of the social and economic conditions of the elderly's life, and this aspect should be incorporated in any serious policy measures.

THE CURRENT STATUS OF THE ELDERLY POPULATION IN KOREA

Demographic and Socioeconomic Profile of the Elderly Population in Korea

The proportion of the elderly population grew from 4.3 percent in 1985 (EPB 1986) to 5.1 percent in 1990 (NSO 1991), and is predicted to be 6.8 percent in 2000 and 12.5 percent in 2020 (KICP 1991). Although the increase

in the proportion of the aged is largely due to the decrease in the birth rate, the sustained increase in life expectancy is also a significant factor which will further expand its importance in the coming years. Life expectancy at birth in 1985 was 71.3 for females and 64.9 for males, and it is expected to be 76.2 for females and 69.3 for males in 2,000 (Choe 1989). While the increased life expectancy itself is an important indicator of the elderly's welfare, the extended life span for each elderly person requires more and more familial and social resources to be spent on elderly care.

Among other demographic characteristics of the elderly population, sex ratio (females = 100) in 1990 was 75.49 for the aged 60 to 64 years, 71.45 for the aged 65 to 69 years, 54.78 for the aged 70 to 74 and 43.49 for the aged 75 and over (NSO 1991). Concerning the marital status of the female elderly as of 1990, 51.97 percent of the aged 60 to 64, 39.08 percent of the aged 65 to 69, 26.10 percent of the aged 70 to 74, and 12.92 percent of the aged 75 and over were married (NSO 1991). Among the male elderly, in a sharp contrast to females, 92.73 percent of the aged 60 to 64, 89.98 percent of the aged 65 to 69, 84.33 percent of the aged 70 to 74, and 69.76 percent of the aged 75 and over were married as of 1990 (NSO 1991). Since it is females who comprise the majority of the elderly population, we may safely say that the marital status of the average elderly person in Korea is problematic. It is somewhat difficult to systematically estimate the income of elderly people or that of households with elderly members in Korea, because of the importance of self-employment in agriculture, seasonal variations in income, the unmonetized economy, and the difficulty in separating out the elderly's personal income from family income. In general, most of the aged are financially dependent on the family income. According to Koo (1986), only 28 percent of elderly men and 10 percent of elderly women live independently on their own income. According to the report of the City of Seoul (1989), 58.6 percent of the elderly population lean on support from their family members, whereas 39.1 percent are financially independent and 1.7 percent partially family-supported. These results are in contrast with the situation of the Western elderly. About 70 percent of the elderly in developed countries use pension benefits and social securities for their living (Korea Gallup 1990).

The employment rate of the elderly has increased from 25.7 percent in 1970 to 28.4 percent in 1980 to 39.7 percent in 1989 (EPB 1971, 1981; Ministry of Labor 1990). However, most of the elderly are self-employed — in particular, 62.7 percent of them (63.9% of males and 61.1% of females) were either family farmers, forestry workers, or fishermen in 1989. These patterns of elderly employment are deemed significantly related to the generally low levels of education received by the elderly population. In 1990, eighty-five

percent of the elderly were primary school graduates or had education levels lower than that.[1]

Social Support Systems for the Elderly in Korea

1. Living Arrangement and Family Support

Regarding the elderly's residence, while 74.45 percent of the whole population lived in urban areas, only 54.95 percent of the aged people (60 and over) were urban residents in 1990 (NSO 1991). As the heavy rural-to-urban migration since the 1960s principally involved the young population, about half of the elderly population is still accounted for in rural areas, and this proportion is not expected to decline too rapidly in the near future. Thus, sufficient attention needs to be paid to the particular social and economic conditions of the rural elderly population (although the limited scope of this paper does not allow to do so here).

In the 1980s, the rapid increase of young people-headed nuclear households has been responsible for the declining proportion of the households with elderly person(s). For instance, two nation-wide surveys in combine show that the proportion of the households with elderly person(s) decreased from 26.3 percent in 1985 to 22.3 percent in 1988. (However, the absolute number of the households with elderly person(s) increased during the same period.) Despite this trend, the proportion of the households with elderly person(s) only grew from 4.1 percent in 1985 to 5.2 percent in 1988. In the same token, the proportion of the elderly who live by themselves increased from 22.6 percent in 1985 to 24.7 percent in 1988.[2] For a significant and increasing proportion of the Korean elderly population, as these statistics show, the traditional sources of social support for the elderly mainly provided by the cohabiting children are not taken for granted any more.

The process of rapid industrialization in Korea has brought about drastic changes to the basic life patterns of the elderly population. Under the new

[1]There are significant gender differences in the level of education. The educational level of 93.8 percent of the female elderly was primary school or lower, whereas 71.4 percent of the male elderly had such low levels of education (Ministry of Labor 1990).

[2]The proportion of the elderly living by themselves in 1988 was particularly high in counties or rural areas (i.e., 32.8 percent) and lowest in big cities (i.e., 15.9 percent). In the same respect, the proportion of the households with elderly person(s) only out of the total households with elderly person(s) was highest in rural areas (i.e., 30.9 percent) and lowest in big cities (i.e., 14.7 percent). These statistics show that rural elderly, who could easily be considered to enjoy the traditional patterns of filial support in the agrarian social context, in fact confront higher possibilities of becoming entirely separated from children and thus have to support themselves (Lee *et al.* 1989).

highly mobile and non-domestic economic activity-oriented family system, family members cannot ensure the necessary total support, from nutrition to affection, for the aged (Lee and Song 1972; Kim, C. 1982; Park 1985). In this context, social and academic attention has been directed to the role of social support in two ways. First, friends and voluntary associations have been recognized as important social support institutions which may supplement what the family is unable or less able to do. Second, and more significantly, the role of the family for supporting the aged is no longer taken for granted.

Although more often now than before the elderly lean on friends to solve emotional difficulties and participate in social activities to diversify their life, they are still primarily supported by their children in economic, emotional, and other areas (Kim, T. 1981; Park 1985). They still express more satisfaction from contact with family members (You 1980) and show higher levels of mental well-being when living with their family (Lee, J. *et al.* 1984). Not only the living arrangement but also the quality of interaction is related to the mental well-being of the aged person. Those aged people who have less conflict with family members show lower levels of perceived loneliness, anxiety, and pessimism (Leem *et al.* 1985).

There are, however, changes and resultant conflicts in family support. The elderly gradually perceive uneasiness in demanding and receiving instrumental and affectional social support. Both aspects interact in a complex manner. The reason for the elderly's preference for living with the eldest son lies not necessarily in subjective comfort in interaction with him but often in economic consideration and the social norm concerning living arrangements. By the social norm, the elderly feel satisfaction by the very fact of living with the eldest son, regardless of the nature of interaction with him or his wife. Economic consideration comes from the situation that most of the property owned by the elderly parents is given to the eldest son, who in turn is usually the first child who becomes economically established (Kim, T. 1981; Cowgill 1986).

However, these social and economic reasons alone do not secure the mental well-being of the elderly living with the eldest son unless affectional support is also exchanged (Leem *et al.* 1985). T. Kim (1981) describes findings about the conflict between economic and emotional concerns: the aged living with the eldest son are most satisfied with economic support, but least satisfied with emotional support, whereas the aged living with a married daughter express the highest satisfaction with emotional support but the least satisfaction with economic support. In addition to the decline in the affectional component of family support, the weakening of the social norm for the eldest son's support for his parents posits an increasingly worrisome element in elderly people's life.

TABLE 1. AGING OF THE KOREAN POPULATION (1960-2020)

Year	Total population	65 years and over		Dependency ratio (%)			Index of aging (%)	Life expectancy at birth	
	Average annual growth rate (Last 5 years)	Average annual growth rate (Last 5 years)	Of total population (%)	Total	Aged 0-14 years	Aged 65+ years		Male	Female
1960	–	–	3.3	86.0	79.9	6.1	7.7	51.1	57.3
1966	2.7	2.7	3.3	87.9	81.7	6.2	7.6	54.9	61.0
1970	1.9	2.0	3.3	83.3	77.2	6.1	7.8	57.2	64.1
1975	2.0	3.0	3.5	71.1	65.2	5.9	9.1	59.8	66.7
1980	1.5	3.7	3.9	60.5	54.3	6.2	11.4	62.7	69.1
1985	1.8	3.8	4.3	52.4	45.9	6.5	14.3	64.9	71.3
1990	1.3	5.5	5.1	43.9	36.5	7.4	20.1	67.1	73.6
1995	0.9	3.7	5.7	40.6	32.6	8.0	24.5	68.2	75.0
2000	0.9	4.9	6.8	38.8	29.4	9.4	31.9	69.3	76.2
2005	0.7	5.0	8.2	39.8	28.4	11.4	40.2	69.8	76.8
2010	0.5	3.4	9.4	39.9	26.8	13.1	49.1	70.3	77.0
2015	0.3	2.7	10.7	39.3	24.3	15.0	61.5	70.8	77.0
2020	0.1	3.4	12.5	39.9	22.4	17.5	78.2	71.3	77.0

Notes: Data from 1960 to 1990 are census data.
Data from 2000 to 2020 are estimated data.
Sources: EPB (1960, 1966, 1970, 1975, 1980, 1985); NSO (1991); Choe (1989, p. 10); Korea Institute for Consumer Protection (1991, pp. 31-33).

2. Support from Friends and Participation in Social Activities

Although an increasing number of the aged participate in social activities through senior citizen centers, senior citizen schools, village or block meetings, voluntary associations, and informal friendship networks (Korea Gallup 1990; Leem *et al.* 1985), the majority of the elderly still spend most of their time at home. A survey of the aged in Seoul reported more than half of the elderly women (79.4 percent) and about half of the elderly men (48.7 percent) usually spent time at home reading, watching television, taking care of grandchildren and so on; only 20.2 percent of the elderly women and 51.3 percent of the elderly men spent time outside of the house attending senior citizen centers, senior citizen schools and visiting the homes of friends or married children (Lee, H. 1979). Informal social activities usually take place among friends, so friends are deemed a central component of the elderly's nonkin support network. Beside friends, the increasing function of senior citizen centers as social support institutions is being acknowledged, and the

TABLE 2. PROPORTIONS OF ELDERLY HOUSEHOLDS AND POPULATIONS (AGED 60 & OVER)

Categories	1985	1988
Households with Elderly Person(s)/ Total Households	26.3	22.3
Households with Elderly Persons(s) Only/ Total Households	4.1	5.2
Households with Elderly Person(s) Only/ Households with Elderly Person(s)	20.5	22.9
Elderly Population/Total Population	6.8	7.1
Elderly Population Living by Themselves/ Total Population	1.7	1.9
Elderly Population Living by Themselves/ Eiderly Population	22.6	24.7

Source: Lee *et al.* (1990, p. 59).

central and local governments have provided some financial and administrative support for building senior citizen centers.[3] Concerning friendship as a social support institution, its affectional function is deemed particularly important. You (1980) found that friendship enhances aged people's emotional satisfaction. She reported that elderly people preferred to share their loneliness and exchange their emotional problems with peers. Most of them have congenial friends within walking distance. Interaction between contemporaries who have interests and experiences in common appears to increase emotional understanding more easily than interaction with other age groups.

Social activities through senior citizen centers, senior citizen schools, village meetings, and voluntary associations may provide opportunities for the elderly to enjoy social relations and acquire instrumental services. Accordingly, J. Kim (1986) reported that social activities and educational activities through senior citizen centers and other institutions significantly improved the elderly's life satisfaction. The function or implicit goal of these social activities is usually so diffuse that affectional and instrumental support almost inseparably occur.

[3]The likelihood of joining social activities through senior citizen centers or other institutions varies according to economic status and gender. Men in general and the financially stable elderly, showed higher interest and actual participation in group activities (Lee, K. 1987; Korea Gallup 1990). Therefore, institutional efforts are encouraged not only to expand scope but also to correct this unevenness between the different social groups of the elderly.

Health Status of the Korean Elderly

1. Physical Health Status of the Elderly

Physical health is largely considered to have been substantially enhanced owing to socioeconomic modernization in Korea. Physical health is a crucial element of the elderly's welfare not only for its own significance but also as a determinant of mental well-being (Kim, J. 1986, p.159). Much evidence suggests that physical illness is in fact a critical concern for the majority of the elderly. A nationwide survey of 977 individuals (60 years and over) in 1985 also showed that 54 percent of men and 45 percent of women rated themselves healthy while 40 percent of the respondents reported health problems such as dental problems, visual impairment, and difficulty in walking long distances (Huh and Rhee 1985). The lower level of physical health among the female elderly appears to be either due to the higher proportion of women in the old age groups (women live longer than men) or to some kind of social segregation based on gender with regard to health care delivery (women have less access to medical care), or due to both.

Regarding the ability to cope with activities of daily living, a majority of the elderly (including some of the physically ill) appear to be able to take care of daily activities. Huh and Rhee (1985) reported that 71 percent of elderly were able to accomplish all IADL (instrumental activities of daily living, that is, eating, dressing, caring for one's appearance, walking, getting in and out of bed, shopping and handling one's own money and so on).[4]

The elderly population suffer most from diseases related to the musculoskeletal system and connective tissue, the respiratory system, and the digestive system (see Table 3). There were also gender differences in prevalent diseases. Female elderly in all age groups showed the highest prevalence rate in the disease of the musculoskeletal system and connective tissue; whereas male elderly showed the highest prevalence rate in the disease of the respiratory among the aged 55-74 and in the disease of the musculoskeletal system and connective tissue among the aged 75 and over.

Although modernization as a general path of socioeconomic change is held to enhance the elderly's physical health, two concomitant changes, economic conditions and social support, seem to cause a more complex picture. As mentioned earlier, most of the aged feel some financial difficulties, and also

[4]As shown in Table 3, the disease prevalence rate of the elderly in 1985 were 1.2 to 1.6 times higher than that of the total population. Among the elderly, those aged 75 and over showed rather lower levels of disease prevalence than those aged 55 to 74. This trend was observed for both men and women.

TABLE 3. DISEASE PATTERNS OF ELDERLY IN KOREA (IN 1,000 PERSONS)

Categories		All ages	55-64	65-74	75 & over
Infectious & Parasitic		5.2	8.3	6.8	5.3
Neoplasms		0.7	2.5	2.1	–
Endocrine, Nutritional & Metabolic & Immunity Disorders		2.5	12.3	4.8	7.1
D. of Blood & Blood Forming Organs		1.7	2.9	4.8	1.8
Mental Disorders		1.2	1.4	0.7	5.3
D. of the Nervous System & Sense Organs		8.5	7.9	13.6	5.3
D. of the Circulatory System		9.8	37.5	42.3	26.6
D. of the Respiratory System		92.7	72.1	82.5	63.7
D. of the Digestive System		38.4	67.4	46.4	28.3
D. of the Genitourinary System		3.5	4.7	3.4	5.3
D. of the Skin & Subcutaneous Tissue		9.8	8.7	6.8	3.5
D. of the Musculoskeletal System & Connective Tissue		32.7	107.4	116.6	93.8
Symptoms, Signs & Ill-Defined Conditions		18.8	29.5	34.1	30.1
Injury & Poisoning		11.7	24.1	22.5	10.6
Total	All	238.4	386.5	387.5	286.7
	Male	216.75	350.3	386.5	299.0
	Female	259.95	420.3	388.2	280.3

Source: MOHSA (1986, pp. 11-15).

feel that familial social support for them is declining, with no conspicuous substitute emerging. Timely medical treatment and care, needless to say, are much affected by these factors. While financial problems are expected to improve in the future for the average elderly person (as the Korean economy consistently grows and social security mechanisms are being introduced), social support is a complex issue for the future of the Korean elderly.

2. Mental Health Status of the Elderly

There is much evidence for the rapid increase of the elderly neuropsychiatric patients since the 1960s (e.g., Kim, C. 1982). The number of in- and out-patients in neuropsychiatric clinics has increased sharply (KNNH 1981). It should be taken into account that the aged population has grown more rapidly than the younger population, while neuropsychiatric hospitals have

become more accessible, affordable, and perhaps socially acceptable. However, the primary cause of this sharp increase of elderly mental patients is probably due to their new patterns of life imposed under industrialization and urbanization (Kim, C. 1982).

According to many surveys of the aged, the majority of the aged suffer from psychological discomfort of one kind or another and aging causes an increase in loneliness, anxiety, and depression. One nationwide survey in 1985 of those aged 60 and over (977 respondents) showed that 63 percent of the men and 48 percent of the women in Seoul and 59 percent of the men and 35 percent of the women in rural areas had cognitive difficulties such as sleep difficulties, worry, loss of interest, depression, fatigue, forgetfulness, hallucinations, and paranoia (Huh and Rhee 1985). In a 1989 survey of 320 elderly patients (60 years and over) visiting public health centers, clinics and hospitals for medical treatment, 53.7 percent of the surveyed reported need for mental support (Rhee and Park 1990). The prevalent mental illnesses of the elderly are organic brain disorders, alcoholism, and depression.

There are some differences in the likelihood of mental illness based on sex and other social characteristics of the elderly. Female elderly tend to report higher life satisfaction than male elderly (Kim, J. 1986). A study (using Zung's self-rating depression scale) of 339 male elderly and 522 female elderly in Seoul and Taegu during the period from October 1983 to June 1984 reported that female elderly were more likely to complain about their depressive symptoms than male elderly. However, mentally ill male elderly showed more serious depressive levels than their female counterparts.

Also the elderly's education and financial situation, among others, were significantly related to depression scores. Concerning education, the less educated show higher depression and lower life satisfaction than the better educated (Lee, J. *et al.* 1984; Kim, J. 1986). Most of the aged do feel economic difficulties, as mentioned already. Poor financial conditions — typically indicated by deficiency in pocket expenses for snacks, cigarettes, drinks, entertainment, transportation, travel, and gifts to children or grandchildren — are observed to cause depression (Lee, J. *et al.* 1984). In a study by Kwon *et al.* (1986), the elderly expressed the belief that financial difficulty is their most stressful concern. Although these socioeconomic conditions and demographic characteristics of the elderly are undoubtedly important factors for the notable increase of mental illness in this age group, it is the changes in family structure that appear to have the primary significance for this aspect of the elderly's life.

THE RELATIONSHIP BETWEEN SOCIAL SUPPORT AND HEALTH OF THE ELDERLY: THE RESULT OF AN IN-DEPTH ANALYSIS

The preceding overview of Korean elderly's socio-demographic and economic conditions, relationships with family and friends, and mental and physical health suggests that rapid economic development and accompanying social change have ramified much complex problems and pressures on elderly life rather than a mere material affluence. In particular, it is paradoxical that the familial social support system has gradually weakened when its importance for the demographically expanding and psychologically disturbed elderly population is more crucial than ever. On the other hand, the state-financed and/or state-organized public mechanisms for delivering institutional care for the elderly have not been fully developed in any meaningful sense. Under these circumstances, the need for rigorous analysis of the precise health impacts of both kin and nonkin social support for the elderly is enormous, particularly if economically efficient as well as socially acceptable policy measures are to be developed. In the second part of this paper, let me introduce the analytical outcomes of my own survey of Korean elderly's social support and health status.

This study was conducted to examine the impact of social support on the mental well-being and self-reported physical health of Korean elderly and, as a result, find out the target elderly population who are in need of various types of public and individual social support. This survey of 1987 was done as a follow-up on a sample of 102 elderly in Seoul selected for a 1984 nationwide survey (see Suh 1989 for details). The 1984 survey was conducted by the Korea Institute for Population and Health on the socioeconomic, physical, and psychological living conditions of 3,704 elderly people. In 1987, the 102 elderly people in Seoul were interviewed using a questionnaire which is much more comprehensive than the 1984 KIPH survey in regard to social support, self-reported physical health, and mental well-being. Social support network was measured by McCallister and Fischer Scale (1978), physical health was measured on the scale developed in the "Human Laboratory Survey" by Belloc, Breslow and Hochstim in 1971. Overall mental well-being was the combination of life satisfaction (measured on Life Satisfaction Index Z) and depression (measured on Zung's Self-Rating Depression Scale).

Social Support Network and Self-Reported Physical Health

In contrast to the results of most studies of Western elderly (e.g., Bultena and Oyler 1971; Berkman and Syme 1979), social support did not significantly

enhance the elderly's self-reported physical health in this study of Korean elderly. That is, only a weak relationship between amount of social support (size of the social support network) and self-reported physical health was found. This result was sustained in the case where all socioeconomic and demographic characteristics were controlled (see Table 4). It may be possible that mobilization of social support during crisis situations (Israel 1985) — illness induces an increase in the elderly's social support network — produced a confounding effect on the weak relationship between social support and self-reported physical health. However, healthier people normally have larger support networks as they can be more socially active and mobile. Also, as the Korean elderly's social support networks mainly consist of kin members, their physical health level may not directly affect the network size. It is implied that a mere amount of social support may not directly influence the elderly's physical health and that more attention has to be paid to the quality or content of the social support delivered in each incident of social support.

Among socio-demographic and economic characteristics, pocket expenses and age were observed to have positive associations with self-reported physical health. Considering the influences of socio-demographic variables on self-reported physical health, a positive relationship between more pocket expenses and better self-reported physical health may well be expected. But a positive relationship between age and self-reported physical health was somewhat unusual, as there is generally an inverse relationship between age and health (Maddox 1964). Concerning the age-physical health relationship, one possible explanation lies in the age-based selection of healthy elderly. In other words, persons living longer may do so because of their better health. Also, the male elderly had better health than the female elderly. The finding on the gender-physical health relationship may be in part attributed to the particular culture of Korea, which is highly female-segregative. Considering this social context, the lower level of female elderly's health can be interpreted as an outcome of the sociocultural structure by which males acquire more resources for health services.

When specific components of social support were considered, kin and instrumental networks were observed to be most important for the elderly's self-reported physical health.[5] Further qualification of this finding was allowed by a more detailed specification of social support. When the different

[5]Instrumental support refers to the support activities concerning transportation, grocery shopping, meal preparation, laundry, daily activities, pocket expenses, and financial problems; affectional support refers to the support activities concerning social activities, social events, personal worries, family problems, important personal decisions, and friendship.

TABLE 4. THE IMPACT OF SUPPORT NETWORK SIZE ON SELF-REPORTED PHYSICAL HEALTH (IN TERMS OF OLS REGRESSION COEFFICIENTS).

	Intercept	[A] Age	Sex (female = 1)	Marry (married = 1)	Educ	Econ	[B] NS	Adj R-sqr
[A]	5.448	.225*	−2.440^{+}	.204	.626	1.472**		.264**
[A + B]								
B: total	5.046	.202^{+}	−2.664^{+}	−.026	.433	1.370**	.296^{+}	.278**
B: kin	4.480	.209*	−2.682^{+}	−.208	.602	1.385**	.420^{+}	.285**
B: nkin	5.552	.220*	−2.442^{+}	.254	.540	1.440**	.168	.259**
B: instr	5.752	.192^{+}	−2.678^{+}	−.144	.555	1.327**	.534*	.300**
B: affec	4.092	.224*	−2.445^{+}	.144	.584	1.430**	.148	.260**
B: kin-instr	4.892	.198^{+}	−2.670^{+}	−.152	.567	1.346**	.526*	.299**
B: kin-affec	4.830	.225	−2.440^{+}	.202	.626	1.471**	.002	.256**
B: nkin-instr	5.258	.211^{+}	−2.440^{+}	.303	.604	1.428**	.926	.262**
B: nkin-affec	5.379	.218*	−2.469^{+}	.260	.502	1.422**	.260	.262**

$^{+}p < .10$; $*p < .05$; $**p < .01$

Notes: [A] represents socio-demographic variables (age, sex, marital status, level of education, pocket expenses); [B] represents each type of social support network size (total support, kin support, nonkin support, instrumental support, affectional support, kin-instrumental support, kin-affectional support, nonkin-instrumental support, nonkin-affectional support).

impacts of kin-instrumental, kin-affectional, nonkin-instrumental, and nonkin-affectional networks were compared, only the kin-instrumental network was seen as a significant determinant of the elderly's self-reported physical health.

In many studies of the Korean elderly, social support from family and other kin members had been found generally to perform significant instrumental functions. Furthermore, self-reported physical health has been reported to be affected largely by instrumental, rather than by affectional social support. In the same token, the importance of kin-instrumental support for the elderly's self-reported physical health was clearly documented by the data provided in this study. On the other hand, nonkin and/or affectional network of social support proved to be only insignificant in affecting the self-reported physical health of the aged.

Main and Buffering Effect of Social Support

1. Main Effect of Social Support

The findings show that social support by kin had an influence on mental well-being (see Table 5). On the other hand, the significance of nonkin support (which had been extended from U.S. and Western experiences) was low in Korea. Specifically, neither nonkin-instrumental nor nonkin-affectional support generated a noticeable impact on the elderly's mental well-being. By contrast, the importance of kin support was manifested both in instrumental and affectional ways. Instrumental and affectional support in general seem to have had significant influence on the elderly's mental well-being. When their subcategories were examined, as implied above, only kin-instrumental and kin-affectional support affected mental well-being. When self-reported physical health was examined as a determinant of the elderly's mental well-being, it also proved to be significant. Its influence was strongly maintained in the models estimated with different social support variables.

Among economic and socio-demographic variables, pocket expenses (or more generally financial difficulty) was observed to affect the elderly's mental well-being. Taking into account that Korea is a not-yet-affluent society which lack comprehensive social security mechanisms for the growing elderly population, the financial situation is regarded as an essential condition for the psychological health of the aged. Education may also have some effect on the elderly's mental well-being, but that effect was rather indirect through self-reported physical health.

2. Buffering Effect of Social Support

The next question to be discussed is whether social support, especially

TABLE 5. THE IMPACT OF SUPPORT NEWTOWK SIZE ON OVERALL MENTAL WELL-BEING (IN TERMS OF OLS REGRESSION COEFFICIENTS).

	Intercept	[A] Age	Sex (female = 1)	Marry (married = 1)	Educ	Econ	[B] PH	[C] NS	Adj R-sqr
[A]	45.730**	.058	.006	1.986	1.756*	4.076**			.360**
[A + B]	38.010**	−.180	2.576	1.771	1.096	2.526**	1.053**		.546**
[A + B + C]									
C: total	40.677	−.218**	1.898	1.254	.692	2.389	.988**	.683**	567*
C: kin	39.330**	−.200	1.684	.693	1.094	2.445**	.952**	1.121**	.586**
C: nkin	38.044**	−.180	2.575	1.776	1.088	2.524**	1.054**	.016	.541**
C: instr	40.874**	−.212	1.950	1.220	1.040	2.432**	.956**	.875*	.566**
C: affec	37.181**	−.180	2.505	1.474	.900	2.346**	1.035**	.736+	.557**
C: kin-instr	40.142**	−.203	1.974	1.208	1.058	2.458**	.960**	858*	.566**
C: kin-affec	33.842*	−.151	2.680	.924	1.364+	2.402**	1.053**	1.349*	.566**
C: nkin-instr	38.236**	−.182	2.572	1.793	1.092	2.520**	1.052**	.420	.540**
C: nkin-affec	38.312**	−.183	2.549	1.806	1.024	2.502**	1.050**	.154	.541**

+p < .10; *p < .05; **p < .01

Notes: [A] represents socio-demographic variables (age, sex, marital status, level of education, pocket expenses); [B] represents self-reported physical health; [C] represents each type of social support network size (total support, kin support, nonkin support, instrumental support, affectional support, kin-instrumental support, kin-affectional support, nonkin-instrumental support, nonkin-affectional support).

when provided by kin members, play a particularly significant role for those elderly who suffer from a difficult life situation caused by poor physical health. In this study of the relationship between social support and mental well-being, the critical interest in dealing with self-reported physical health consisted of the interactive mechanism between social support and physical health. This interactive mechanism magnifies the effect of social support on mental well-being for those elderly in poor physical health.

This line of analysis was intended to test a "buffering effect" of social support against psychological distress generated by poor physical health. For this analysis, the respondents were divided into two groups with low and high levels of physical health, based on the median score of self-reported physical health. An equation which explains the impact of control variables alone was estimated first, and then the social support variables were put into the equations at different steps.

Tables 6 and 7 display the different effects of social support network on mental well-being between the high and the low physical health group. For the physically healthy elderly, the impact of social support network was not observed at all. Thus, the above highlighted role of the kin network for the elderly's mental health, as well as that of the nonkin network, was not borne out among the physically healthier elderly. Among the socio-demographic variables, pocket expenses had a significant effect on mental well-being in all the equations. None of the equations had statistically significant explanatory power (in terms of R-square) at the conventional significant level of .05, although they were significant at the .10 level. In sum, the physically healthy elderly's mental well-being was not much affected by social support or by other socio-demographic variables (except by pocket expenses).

In contrast, the impact of social support network on the mental well-being of the elderly in the low physical health group was largely significant and mirrors what has been observed concerning the entire group of elderly people. The total support network showed a significant impact on mental well-being of the low physical health group, confirming the buffering effect of social support at a general level. Also, kin, instrumental, and kin-instrumental social support displayed their importance as the core mechanisms of social support in buffering the negative psychological consequences of physical illness, as the corresponding coefficients were all significant for the low physical health group. Among socioeconomic and demographic variables, pocket expenses produced a significant impact on mental well-being in the positive direction. Education was another, though less important, factor which showed a buffering effect. Marital status showed some effect of the same kind, but its statistical significance was hardly tenable. As many factors

TABLE 6. HIGH PHYSICAL HEALTH GROUP (N = 54): THE IMPACT OF SUPPORT NETWORK ON OVERALL MENTAL WELL-BEING (IN TERMS OF OLS REGRESSION COEFFICENTS)

	Intercept	[A] Age	Sex (female = 1)	Marry (married = 1)	Educ	Econ	[B] SN	Adj R-sqr
[A]	60.238**	.001	4.539	2.276	1.086	1.954*		.129^{+}
[A + B]								
B: total	63.095**	−.048	3.580	1.475	.555	2.094*	.418	.126^{+}
B: kin	62.998**	−.058	3.447	.990	.821	2.271*	.577	.134^{+}
B: nkin	60.093**	.002	4.567	2.254	1.144	1.969*	−.070	.108^{+}
B: instr	63.364**	−.054	3.627	1.330	.824	2.129*	.470	.127^{+}
B: affec	61.146**	−.026	4.181	1.474	.748	1.927*	.726	.141^{+}
B: kin-instr	63.070**	−.050	3.652	1.320	.849	2.148*	.448	.124^{+}
B: kin-affec	59.516**	−.018	4.529	1.134	1.330	2.122*	.898	.143^{+}
B: nkin-instr	59.776**	.064	4.666	2.572	1.063	1.884*	1.626	.122^{+}
B: nkin-affec	60.737**	−.002	4.422	2.316	.908	1.899*	.243	.109^{+}

$^{+}p < .10$; $^{*}p < .05$; $^{**}p < .01$

Notes: [A] represents socio-demographic variables (age, sex, marital status, level of education, pocket expenses); [B] represents each type of social support network (total support, kin support, nonkin support, instrumental support, affectional support, kin-instrumental support, kin-affectional support, nonkin instrumental support, nonkin-affectional support).

TABLE 7. LOW PHYSICAL HEALTH GROUP (N = 48): THE IMPACT OF SUPPORT NETWORK ON OVERALL MENTAL WELL-BEING (IN TERMS OF OLS REGRESSION COEFFICIENTS).

	Intercept	[A] Age	Sex (female = 1)	Marry (married = 1)	Educ	Econ	[B] SN	Adj R-sqr
[A]	51.066**	−.113	3.434	4.607	2.092*	3.010**		.334**
[A + B]								
B: total	48.422**	−.122	2.630	4.825+	1.903*	2.302**	1.151**	.437**
B: kin	38.402**	.006	1.772	4.586+	2.624**	2.013**	1.955**	.477**
B: nkin	52.370**	−.141	3.590	4.843+	1.930+	2.933**	.650	.355**
B: instr	44.154*	−0.67	2.461	5.200+	2.507**	2.240**	1.658**	.423**
B: affec	47.092**	−.078	3.331	4.774+	2.025*	2.700**	.790	.350**
B: kin-instr	42.512*	−.043	2.522	5.262+	2.504**	2.234**	1.644**	.424**
B: kin-affec	43.736*	−.025	3.175	4.504	2.279*	2.718**	1.074	.332**
B: nkin-instr	47.068*	−.056	3.560	4.778	2.094*	2.978**	−3.866	.323**
B: nkin-affec	52.492**	−.142	3.522	4.851+	1.886+	2.914**	.794	.340**

+p < .10; *p < .05, **p < .01

Notes: [A] represents socio-demographic variables (age, sex, marital status, level of education, pocket expenses); [B] represents each type of social support network (total support, kin support, nonkin support, instrumental support, affectional support, kin-instrumental support, kin-affectional support, nonkin-instrumental support nonkin-affectional support).

produced significant impacts on mental well-being, all equations in Table 7 had significant explanatory power (in terms of R-square) at the .01 of significance.

Considering these two contrasting sets of results with the high and the low physical health group, a clear documentation of the so-called "buffering effect" of social support was possible. In fact, not only social support, but also pocket expenses, education, and marital status seemed to have some buffering functions in that the latter factors also showed differential impacts on mental well-being depending on the elderly's self-reported physical health status. The practical implications of these findings will be discussed subsequently.

CONCLUSION

By and large, the recent social concern about the life of the elderly in Korea revolves around the gradual decline of the extended family as the prime institution for supporting the elderly. The results of my in-depth analysis of Korean elderly's mental and physical health as well as the minimal welfare benefits available for most elderly people, however, signal that most Korean elderly still turn to their families for both instrumental and affectional support. The sustained importance of kin support under rapid socioeconomic modernization not only differentiates the Korean situation from the Western experience but also suggests a different way of coping with the growing aged population. As in other Asian societies, "the West as a model" (Martin 1988, p. S109) may not be acceptable at its face value for Korea.

Given the yet preserved tradition of strong and comprehensive familial ties in Korea, the family still appears not only the most important but also the most efficient social institution for supporting the elderly. Hence, every effort should be made to encourage families to continue supporting their elderly. Ultimately, a strong sociocultural tradition may not be a sufficient condition for preserving the social support function of the family. Thus, active governmental policies and social campaigns may have to complement the tradition *per se* in elderly care. For example, serious financial support programs such as subsidies and tax redemptions for those families with dependent elderly person(s) need to be developed and expanded in addition to medical insurance and old-age pension.

The sustained significance of kin support for Korean elderly may not present only a fortunate situation for the elderly population and society. It could, in fact, allude to a fundamentally problematic situation, that is, lack of alternative sources of social support for the elderly. In my in-depth analysis,

this problem was indirectly shown by the insignificant role of nonkin social support for the elderly's mental and subjective physical well-being. Of course, even a very sketchy examination of the currently available welfare benefits for the elderly will reinforce this line of judgment. The support function of the family can be crucial, not only when the sociocultural tradition is strongly maintained, but also when no major alternative sources of social support are available for the elderly. Although the former is largely deemed to be the case, the latter is also an undeniable and increasingly visible reality.

In Korea, comprehensive social security programs for the elderly are not yet available and extra-familial private mechanisms for social support are rare. While kin social support for the elderly needs to be further encouraged, more social and political attention and economic investment should be made to develop complementary, rather than substitutive, mechanisms of social support. Institutional arrangements for social, cultural, and educational activities including senior day care centers, senior citizen centers and senior citizen schools are such complementary mechanisms. More comprehensive financial support programs for the elderly, such as subsidies and pensions, may be introduced and expanded in the future. But these programs should also be complementary to other available sources of social support.

The emphasis on the complementary nature of the prospective means for social support is congruent with the emphasis on need, rather than age, as the criterion for allocation of resources (Martin 1988, p. S111). Age-based programs, such as pensions for the elderly in less developed countries, have been criticized as perpetuating an already unequal distribution of income and opportunities. Therefore, social support programs for the elderly should fully reflect the different realities of available kin and nonkin support for the different socioeconomic groups of the elderly in Korea. In other words, social support programs should touch on those who are actually sick, poor, and helpless but do not have close caregivers.

The significant buffering effect of social support (and some socioeconomic factors) as presented in my in-depth analysis of Korean elderly's physical and mental health suggests that a macroeconomic rationale can be derived concerning the need-based social support programs. Since the social and financial resources of the state and individual families are limited, they should be allocated to reflect the actual needs and difficulties of the elderly (in particular, concerning health conditions), so that their buffering effects are fully manifested against stressful life events. In this way, the social utility of social support mechanisms, whether public or private, will be maximized. Specifically concerning the particularly significant buffering effect of kin-instrumental support, those poor families with ill elderly parent(s) or relative(s) must be financially supported in their delivery of material care for the elderly.

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