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Actual Conditions of Elderly Abuse by Family Members and Related Policy Issues

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Contents

Tables

Figures

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Ⅰ. Backgrounds and Objectives

As of August 2017, the population of people aged 65 and above reached 7,287,288 in Korea. Thus, Korea turned into an “aged society” as the proportion of the elderly exceeded 14.0% of the total population (51,753,820). About a year later, the number of people over 65 stood at 7,582,353 as of September 2018, accounting for 14.6% of the total population (51,817,851). Korea is on its way to becoming a “super-aged society”, a society in which more than 20% of the population is over 65. Additionally, as for the gender distribution in the elderly population (as of September 2018), there are 4,341,759 women, accounting for 57.3% of those over 65 and apparently not much more than their male counterparts. However, the gap significantly increases between genders as the age goes up. For the population over 80, women account for 67.8%; for those over 80, women take up 77.4% of the said population (Ministry of Public Administration and Security Website, 2018). Consequently,

ageing in Korea can be seen as an issue very pertinent to women. Thus, the need is great to treat issues related to the elderly from a gender perspective and to provide appropriate policy support. However, the importance of women and gender is currently being overlooked by ageism.

Meanwhile, the population of elderly people experiencing abuse is on the rise. According to the *National Survey of Older Koreans*, over the past decade, one in ten senior citizens aged 65 or above have been reported to have experienced physical, emotional, verbal and/or sexual abuse by their family members or neighbors. Of the abused, the proportion of women is relatively higher than that of men. Additionally, the *Japanese Statistics on Elder Abuse* showed that one in four elderly people have been abused during family care.

Older women are required to play a leading role in caring for their families even in old age. Many members of the families for which the elderly women provide care are weak in their physical and cognitive functions. Thus, during the care process as spouse or parent, elderly women undergo marital conflict, parent-child conflict, and generational conflict. The older women are also faced with abuse rising from such conflicts. Elderly women also need care as they age. Thus, giving them the role as the main caregiver in the family can have a fatal impact on the health and quality of life of elderly women. In particular, elderly women are much more financially dependent on their spouses and families than in any period of their life cycles. Consequently, it becomes increasingly difficult for older women to respond or ask for outside help even when they are abused by their families.

While the proportion of women among elder abuse victims has been increasing significantly, measures for prevention of elder abuse currently

lack a gender perspective. One of the reasons for this lack is the absence of gender analysis of elder abuse.

The Korea Elder Protection Agency (KEPA), an organization commissioned by the Ministry of Health and Welfare, annually compiles statistics on the status of elder abuse. This study contacted KEPA and received the elder abuse statistics by gender for five years, starting from 2012 to 2016. For data that could not be obtained from KEPA statistics, the study conducted its own survey. With the KEPA statistics and the survey, this study investigated the care and abuse of elderly women as a social health risk factor of the elderly. Through the investigation, this study analyzed the discrimination and inequality of elderly women in Korea's policies for senior citizens, especially in policies for care and abuse. With the analysis, this study aimed to explore the direction for gender equality policies.

Ⅱ. Methodology

To achieve its purposes, this study employed and produced two sets of data.

First, the study conducted a gender analysis on elder abuse statistics as given in the *Status Report on Elder Abuse* compiled by the Korea Elder Protection Agency (KEPA), an organization commissioned by the Ministry of Health and Welfare commissioned. KEPA has analyzed cases reported by local elder protection agencies all over Korea every year since 2005. After analysis, the agency publishes an annual report under the name *Status Report on Elder Abuse* (KEPA website, 2018). According to the *2017 Status Report on Elder Abuse*, the revision of the *Welfare of Older Persons Act* in 2004 laid the legal basis for the

founding of elder protection agencies. Since then, a total of 31 local elder protection agencies and one central elder protection agency has been set up and is currently in operation for the protection of elder rights and prevention of elder abuse (Ministry of Health and Welfare / KEPA, 2018: 3). The *Status Report on Elder Abuse* provides annual statistics on elder abuse reports, the characteristics of victims and perpetrators, and the types of abuse. The publication also includes case analysis by characteristics such as abuse in single-elder homes and facilities, elder abuse by elder, and demented elder abuse (Ministry of Health and Welfare / KEPA, 2018: 5). For this study, the staff member in charge at KEPA was consulted. After consultation, the study requested gender data on the statistics of abuse victims and perpetrators as given in the *Status Report on Elder Abuse*. Gender data from the years 2012 to 2016 were requested.

Second, the study examined the physical and mental health status of elderly women who experienced abuse from their family members or neighbors. This examination was done by looking through the *National Survey of Older Koreans*. Starting from 2008, the *National Survey of Older Koreans* has been conducted every three years in accordance with Article 5 of the *Welfare of Older Persons Act*. To date, four surveys have been conducted (2008, 2011, 2014, 2017); survey subjects are elderly people over 65.

The *National Survey of Older Koreans* identifies the following types of elder abuse: physical, emotional, economic, sexual, (self) neglect, and abandonment. To identify each type of abuse, the survey provides items as follows.

Physical abuse: “I have been physically hurt by others (pushed, hit, etc)”

Emotional abuse: “I have been emotionally hurt by the words and actions of others (not talking, ignoring, pretending to not hear, annoyance, complaining, etc)”

Economic abuse: “I have sustained financial damage from others (using money without consent, forced title transfer, etc.)”

Sexual abuse: “I have been sexually abused or have experienced words/actions that gave me sexual shame.”

Neglect: “My family or caregiver did not care (did not help me with self-maintenance, cleaning) for me (when I was not health).”

Abandonment: “My family or caregiver almost never visited me and/or did not provide any financial support” (K. Jung, et. al., 2017: 862). All of the data utilized for this study examined abuse experience for the past one year of the corresponding survey.

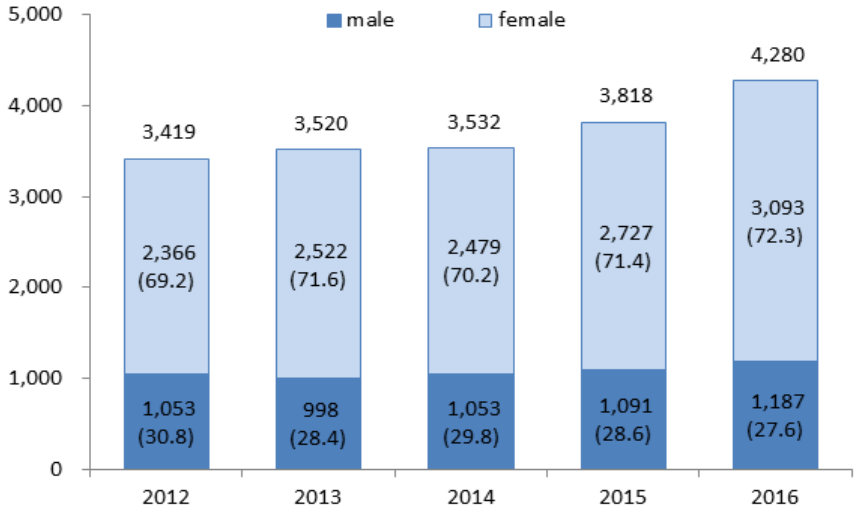
Ⅲ. Results

1. Gender ratio of elder abuse victims

The number of elder abuse cases reported to KEPA increased every year from 2012 to 2016. The ratio of female victims was more than twice that of men.

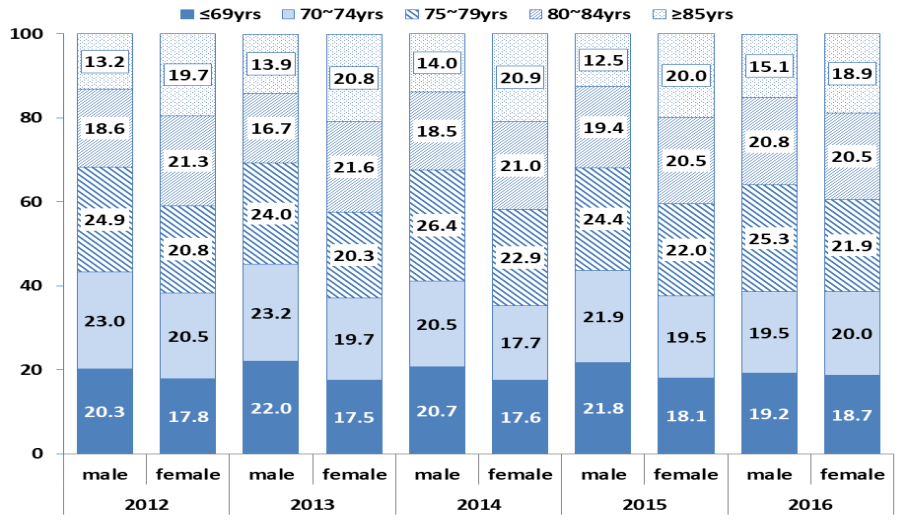
The ratio of abuse at ages 75-79 was more than 20%, high for both men and women. In terms of gender, during the years under study (2012-2016), the ratio of women victims was high at 19-20% in the 85+ age bracket. Meanwhile, for male victims, the under 69 age group showed a high ratio of 19-22%. In other words, as age goes up, so does the ratio of elderly women being abused.

(Unit : cases, (%))



[Figure 1] Cases of abuse and distribution ratio by gender (2012~2016)

(Unit : %)

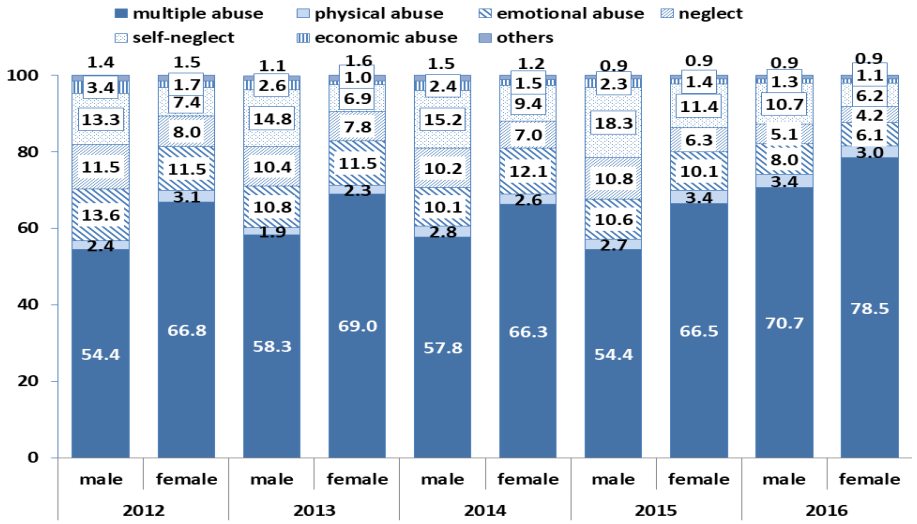


[Figure 2] Abuse victim distribution ratio by gender and age group (2012~2016)

2. Multiple (co-occurring) abuses of elderly women

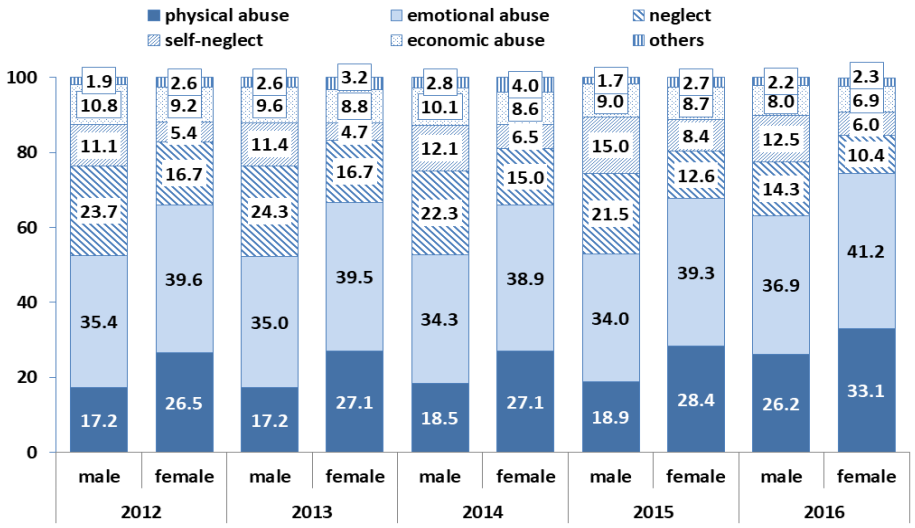
Looking at the types of elder abuse, the ratio of multiple abuse was the highest at 63 ~ 66%. Multiple abuse was shown to be more prevalent among women than men. In terms of the number of cases per abuse type, women reported more cases of emotional and physical abuse than men, while men experienced higher levels of neglect, self- neglect, and economic abuse compared to women.

(Unit : %)



[Figure 3] Ratio of multiple abuse by gender (2012~2016)

(Unit : %)



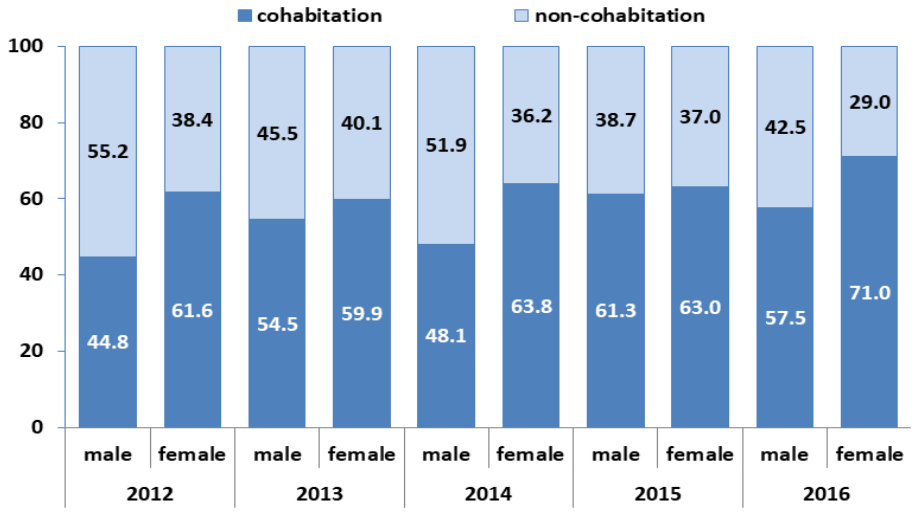
[Figure 4] Abuse distribution ratio by abuse type and gender (2012~2016)

3. Cohabitation of women elder abuse victims with their perpetrators

The ratio of abuse victims living with their abusers is over 50%. Women showed higher percentages of living with their abusers than their male counterparts. Thus, women are more likely to be continually exposed to abuse. When looking at the types of cohabitation, for men, cohabitation with spouse showed the highest ratio at around 30%. The number of men living in facilities and hospitals was higher than that of women. In the case of women, cohabitation with son was highest at around 30%. The ratio of elderly women living with daughter-in-law and daughter was higher than that of men. The most common household type of abuse victims was the single-household which accounted for more than 30%. Currently, however, the percentage of couples is rising

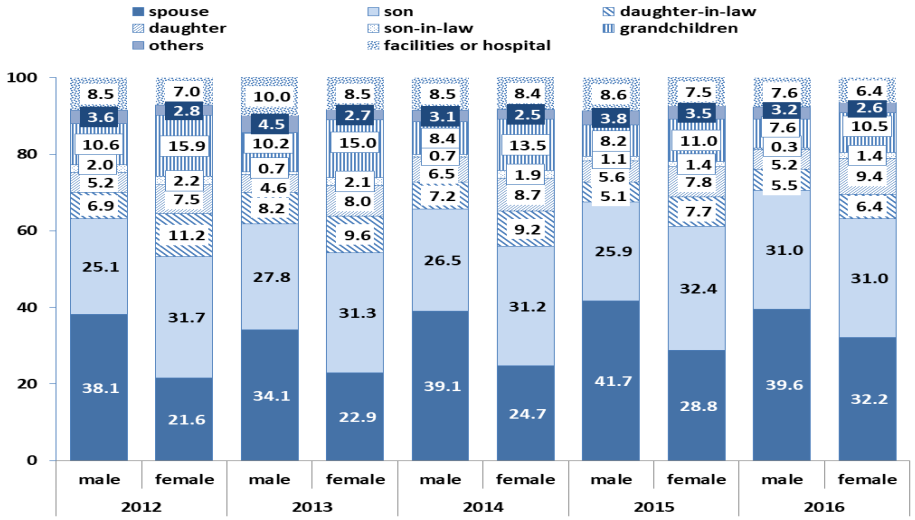
amongst elder abuse victims. In addition, the percentage of single-family household for males is more than 10% higher than that of women. Also, women showed a higher percentage than men in the number of households cohabiting with children and grandchildren.

(Unit : %)



[Figure 5] Gender ratio of abuse victims cohabiting with their abusers (2012~2016)

(Unit : %)



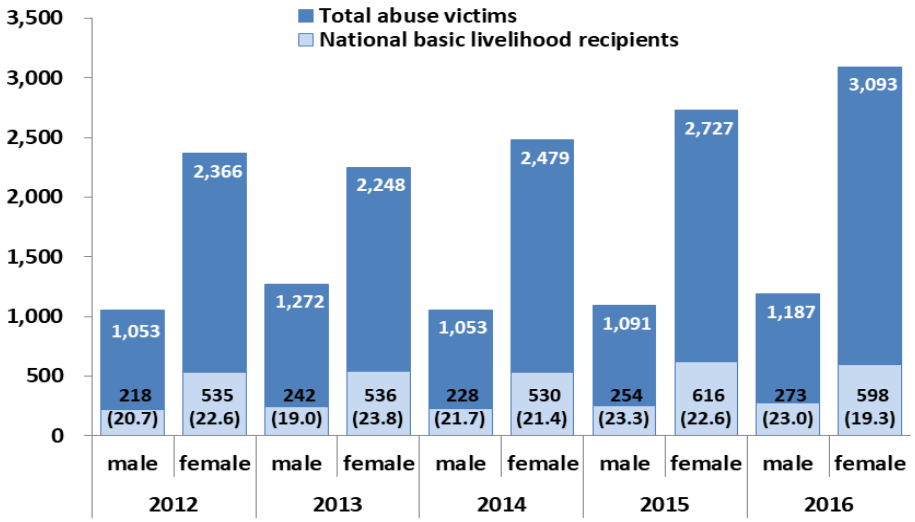
[Figure 6] Type of cohabitors of abuse victims (2012~2016)

4. Social class characteristic of elderly women abuse victims

The proportion of national basic livelihood recipients among abuse victims was 20%. The ratio of women among national basic livelihood recipients was more than twice the men. Such figures show that older women who are financially vulnerable experience more abuse than their male counterparts.

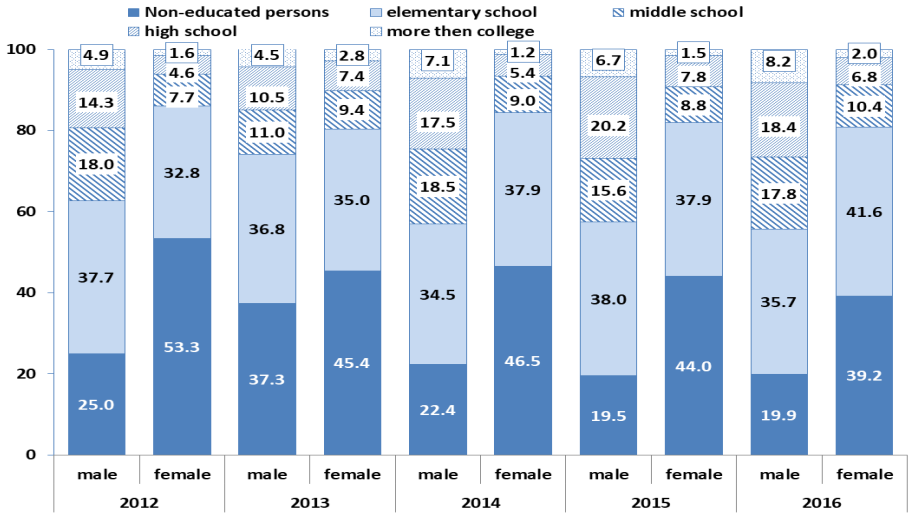
Looking at the education level of abuse victims, the lower the level of education for both men and women, the higher the ratio of victims. Such a pattern was especially more pronounced among women.

(Unit: cases, (%))



[Figure 7] Status of national basic livelihood recipients among abuse victims by gender (2012~2016)

(Unit: %)

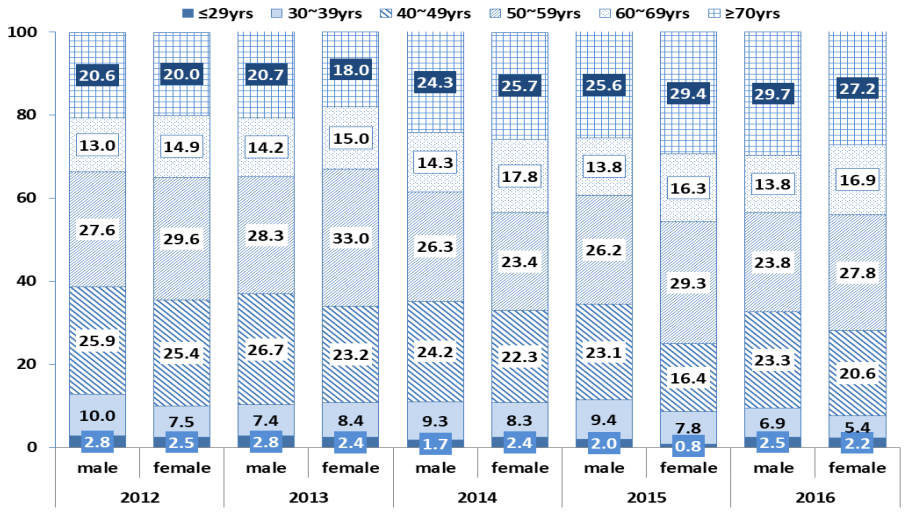


[Figure 8] Education level of abuse victims by gender (2012~2016)

5. Elder-elder abuse and elderly women

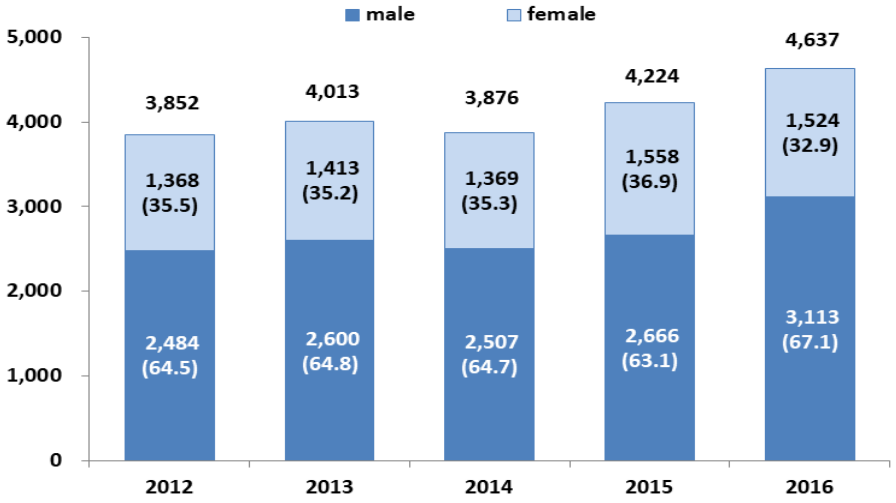
From 2012 to 2016, male abusers accounted for more than 60% of elder abusers. In terms of age, the 40-59 age group accounted for the highest ratio. Recently, the number of abusers over 70 has been gradually increasing. Such an increase is predicted to be correlated with an increase in elder-elder abuse cases (cases in which an elderly is abused by another elderly).

(Unit: cases, (%))



[Figure 9] Number and ratio of perpetrators by gender (2012~2016)

(Unit: %)



[Figure 10] Age distribution of perpetrators by gender (2012~2016)

The ratio of elder-elder abuse among all abusers has continued to increase year after year from 34.1% in 2012 to 34.2% in 2013, 40.3% in 2014, 41.7% in 2015, and to 43.7% in 2016. In particular, the ratio of women victims amongst elder-elder abuse victims was shown to be high at around 72 ~ 75.7%. In other words, the statistics show that, for elder-elder abuse, women elder abuse by the husband occurs more than male elder abuse by the wife.

〈Table 1〉 Number of Elder-Elder Cases and Gender Distribution of Victim and Perpetrator (2012-2016)

(Unit : cases, persons(%))

Category		2012	2013	2014	2015	2016
Elder-elder abuse	Cases	1,312	1,374	1,562	1,762	2,026
	ratio[1)]	34.1	34.2	40.3	41.7	43.7
Victims	Male	367 (28.0)	352 (25.6)	415 (26.6)	454 (25.8)	493 (24.3)
	Female	945 (72.0)	1,022 (74.4)	1,147 (73.4)	1,308 (74.2)	1,533 (75.7)
Perpetrators	Male	835 (63.6)	907 (66.0)	966 (61.8)	1,050 (59.6)	1,355 (66.9)
	Female	477 (36.4)	467 (34.0)	596 (38.2)	712 (40.4)	671 (33.1)

Note: 1) Ratio of elder-elder abuse to total number of abuse

6. Health of elderly women abuse victims

The physical and mental health status of elderly women who had been abused by their family members or neighbors was examined by analyzing the *2017 National Survey of Older Koreans*. The examination revealed that the number of abuse victims who thought they were not healthy was higher than those women who had not experienced abuse. Likewise, the levels of health risks such as the number of chronic diseases, depression, and suicidal thoughts were also relatively higher for abuse victims. Even amongst abuse victims, those who experienced multiple abuse displayed higher levels of health risks than single-abuse victims. In addition, when considering by gender, the health vulnerability (risk) of female victims was higher than that of male victims regardless of single or multiple abuse.

〈Table 2〉 Physical / mental health of elderly women depending on experience of abuse

(Unit: %, cases, persons)

Trait	Non-abuse		Abuse		X2/F (p)	Singular abuse		Multiple abuse		X2/F (p)
	M	F	M	F		M	F	M	F	
Subjective										
Healthy	68.5	55.5	60.9	47.8	197.85 (***)	65.6	51.4	44.0	33.3	223.39 (***)
Unhealthy	31.5	44.5	39.1	52.2		34.4	48.6	56.0	66.7	
No. of chronic disease diag. by doctor	2.27	2.97	2.68	3.58	162.10 (***)	2.62	3.44	2.90	4.16	100.63 (***)
Depression										
Normal	90.5	88.8	81.2	75.8	128.86 (***)	86.8	80.1	61.1	58.3	217.13 (***)
Depressed	9.5	11.2	18.8	24.2		13.2	19.9	38.9	41.7	
Thought of suicide										
Yes	5.0	5.7	16.4	19.6	242.93 (***)	12.9	16.9	28.9	29.8	293.23 (***)
No	95.0	94.3	83.6	80.4		87.1	83.1	71.1	70.2	
Total	3,876 (100.0)	5,205 (100.0)	409 (100.0)	582 (100.0)	10,073 (100.0)	319 (100.0)	467 (100.0)	90 (100.0)	114 (100.0)	10,073 (100.0)

***p<0.001

Ⅳ. Policy Suggestions

1. Addition of elder abuse to elderly health focus projects in the National Health Plan

Since abuse is an important risk factor for the health promotion of the elderly, elder abuse-related indicators must be included in the *National Health Plan 2030*, which will go into preparation starting next year. The indicators should be categorized by gender. This is because gender differences in elder abuse have been observed in the past decade and the ratio of women among the victims of elder abuse has been extremely high.

As mentioned above, 'abuse' is a very important social determinant of health in terms of health care for the elderly, so the relevant indicators must be included in the *National Health Plan 2030*. This will allow the central government and local governments to take interest in and continuously monitor elder abuse and consequently provide a foundation for victim protection and support. In addition, the elder abuse indicators must be created and presented by gender to clearly identify the differences between older women and men in terms of the causes of abuse (personal situation, family composition, health, etc.) and demand. Such gender-differentiated indicators will prove to be valuable in providing support that adequately meets the needs of both male and female abuse victims.

2. Addition of elder abuse to elderly health support services

The current dementia care system consists of the following: dementia prevention, early detection, treatment/management, and care. As the risk of abuse for the demented elderly is high, there is need to also consider elder abuse in the dementia care system. Dementia counseling centers installed nationwide in public health centers are being used for early detection of dementia. Detecting elder abuse along with dementia should be something worth considering. On the other hand, daily-life safety education and the operation of 'safety personnel' to prevent abuse in facilities are being suggested as measures for the protection of the safety and rights of the elderly. However, prevention of elder abuse in the home is not included in these measures. In order to protect the safety and rights of the elderly, it is necessary to prepare measures to prevent not only abuse in the facility but also abuse in the home.

3. Inclusion of elder abuse victims as recipients of home-visiting healthcare

Home-visiting healthcare is a government project aimed to provide customized healthcare services for vulnerable groups by identifying the health problems of the vulnerable groups in a comprehensive manner (Ministry of Health and Welfare, 2017: 13). The 2018 Guideline for Operation, the most recent guideline for the project to date, stipulates the “reinforcement of the role of community health centers for the management of home-visiting healthcare” (Ministry of Health and Welfare, 2017: 8). As an aspect of “health management”, there is need to make full use of home-visiting healthcare service as a resource for early detection and management of elder abuse in the home.

Due to the nature of elder abuse in the home, it is not easy for the abuse to become known outside the home. Oftentimes, abuse victims are not even aware that they are being abused. In this respect, home-visiting specialists may detect elder abuse in the home in its early stages. In addition, elder abuse victims may resist the use of the term “abuse” because the abusers are mostly family members. Therefore, approaching elder abuse in terms of 'health care' could lessen the reluctance of elder abuse victims to respond to questioning.

4. Inclusion of elder abuse-related indicators in home-visiting healthcare health questionnaire

Home-visiting healthcare is provided as follows. Professionals in community health centers such as nurses, physical therapists and dental hygienists visit homes and other living facilities. During the visit, the personnel administers health screening, provides health management

services, and connects recipients with appropriate resources. The service is given to individuals, small groups of 2 to 4 persons, and large groups. For health screening, the visiting personnel utilizes a health questionnaire (Ministry of Health and Welfare, 2017: 21). Health screening is divided into identification of health behaviors/health risk factors and health monitoring. Health monitoring is done for the purpose of "minimizing blind spots of vulnerable groups by finding children or elderly who have been isolated from society and/or have been subject to abuse, neglect, and domestic violence" (Ministry of Health and Welfare, 2017: 29). However, despite the stated purpose, the questionnaire used for health screening does not have enough items related to elder abuse (Ministry of Health and Welfare, 2017: 81-84). Appropriate items can be added to directly or indirectly identify physical, emotional, verbal, sexual abuse and (self) neglect of older people. In addition to the health questionnaire, health monitoring also checks for disease, sensory function and walk test, and depression testing (Ministry of Health and Welfare, 2017: 82-84). Items to identify the risk of abuse can also be added to these additional tests. In addition, the home-visiting healthcare health questionnaire includes items that identifies the characteristics of the recipients of home-visiting healthcare (pregnant women, North Korean defectors, disabled persons, etc.) (Ministry of Health and Welfare, 2017: 85, 89, 95-96). If elder abuse victims are to be included as recipients of home-visiting healthcare in the future, then it would be necessary to create items in the health questionnaire customized for the characteristics of elderly abuse victims.

5. Inclusion of elder abuse professional in the professional group for home-visiting healthcare

The recipients of home-visiting healthcare are defined as the social, cultural and economic health vulnerability groups (health risk groups, disease groups) that have difficulty in availing of healthcare services. Elder abuse victims and the elderly with high risk for abuse should be included as recipients of home-visiting healthcare. In particular, the current recipients of home-visiting healthcare services are selected according to priority listing. Thus, it is necessary to consider where elder abuse victims and the elderly with high risk for abuse should be placed in the priority listing.

6. Use of direct-care workers for locating elder abuse victims and implementation of education for improvement of gender sensitivity

Since direct-care workers visit the homes of elderly people and provide necessary care, they can be one of the first people to spot elder abuse in the home. Consequently, gender sensitivity of home-visiting direct-care workers can be seen as a significant factor for the early-finding of elder abuse.

Introduction to Direct-Care, the standard textbook used for training direct-care workers, provides some general descriptions on the protection of elder rights and prevention of abuse. However, it only deals with legislations, concepts of elder abuse, and statistics and types of elder abuse. The book does not cover contents related to the gender sensitivity of direct-care workers.

Therefore, it is necessary to include contents in the training curriculumthat can enhance gender sensitivity of direct-care workers.

7. Facilitation and strengthening of the effectiveness of elder abuse reporting/counseling system

According to the Ministry of Health and Welfare, 637 cases of elder abuse were reported (call number: 1577-1389) which is a low reporting rate of 13.7%. Therefore, in order to resolve the low reporting rate, the Ministry plans to expand the groups responsible for reporting, strengthen training, and strengthen early-finding and the reporting system. However, in the case of an elder abuse call, the caller may feel hesitant (especially the victims themselves) in reporting the abuse because of the terms ('words') involved. In particular, most of the people who are calling to report elder abuse will already be aware relatively that they are being abused. What is important, then, is to have measures that make it possible to locate elder abuse cases in which the victims are not aware of the abuse and therefore cannot report the said abuse.

8. Inclusion of at-home elder caretakers and elder abuse victims into *Vacation Support Program for Families with Demented Member*

Japan utilizes community care support centers to ensure that care providers do not suffer physical and mental exhaustion while continuing to care for their families. In particular, as the risk of abuse caused by care stress increases, Japan allows exhausted or burnt-out care providers to take a vacation. During the vacation, the gap in care giving is filled by quality services provided by centers. In addition, caregivers make take not only short-term vacations but long-term vacations if necessary.

Likewise, Korea has a *Vacation Support Program for Families with Demented Member*. The program supports family caregivers of people with dementia by giving them vacations when necessary. However, the

recipients of the program are limited to only the demented elderly (by diagnosis) who use the comprehensive elderly care service (home-visit or daytime protection service). Therefore, the current *Vacation Support Program for Families with Demented Member* should be expanded as to include home-care. It may be necessary to consider a step by step expansion. First, elder-elder care situations should be considered and then abuse victims should be considered next.

9. Giving of priority entry to care facilities for elder abuse victims

Elder abuse victims need to be separated from their abusers. However, care facilities with good accessibility and quality services generally have a long waiting list. Consequently, abuse victims often fail to enter such facilities at the time of need. Therefore, in the case of elder abuse victims, elder abuse protection agencies have to temporarily protect the victims by separating the victim from the perpetrator. Should an elderly abuse victim be also an individual needing long-term care, the individual is all the more exposed to the risk of repeated and continuous abuse. Thus, the need exists to look into a measure that can grant priority entry to a public care facility in case the request is made by a elder abuse victim. In some cases, the victim may not personally be able to make the request due to health and/or situational reasons. In such cases, support should be provided in various ways, such as through the aid of direct-care workers and home-visiting healthcare services.

10. Education for family availing of direct-care service

The results of this study showed that the perpetrators of the elder abuse cases were mainly family members of the victims. For women victims,

the majority of the abusers showed to be either the son or the husband and in such cases the victims often lived with the abusers. Consequently, abuse could happen repeatedly and continually. Therefore, there is need to provide education on elder abuse to the families of the elderly as a measure for preventing abuse and its reoccurrence.

In order to enforce this preventive education, it is possible to consider making the education mandatory for families who want to avail of direct-care services, whether at home or in a facility. Currently, some education is being offered for families availing of direct-care services. However, most of such education is provided by individual institutions (facilities). Thus, the scope of education should be enlarged as to include all family members that live with service users.

11. Expand burden of reporting for elder abuse to include all citizens

Elder abuse in the family is difficult to identify, but even if witnessed, it is often not reported because the witness views the abuse as private affairs of the individual and his or her family. Thus, related legislation should be changed to increase reporting rates. Currently, Article 39-6 (Obligations and procedures for reporting elder abuse) in the *Welfare of Older Persons Act* state that '① If anyone comes to know of elder abuse, such persons can report the case to an elder protection agency or to an investigation agency.' There is need to change this clause to '① If anyone comes to know of elder abuse, such persons *must* report the case to an elder protection agency or to an investigation agency.' By making reporting mandatory for all witnesses of elder abuse, the sensitivity of the general public can be raised regarding elder abuse.

12. Development and implementation of treatment program for elder abuse perpetrators under influence of alcohol/drugs[1)]

One of the major causes of elder abuse may be stress that comes from elder care. However, alcohol and drugs can aggravate the stress turning into abuse. Therefore, elder abusers with alcohol and drug abuse problems should be made aware of the problems of elder abuse and alcohol and drug use. They should be motivated towards change and helped in the areas of stress management, anger control, and problem solving. Such help has great potential for decreasing instances of elder abuse.

A relevant treatment program can be composed of initial stage, behavioral change stage, and completion stage. In the initial stage, education and self-diagnosis related to alcohol and violence can be provided. During the behavioral change stage, practical interventions such as stress management, anger control, and problem solving can be administered to motivate change in the abusers. Finally, in the completion stage, the program participant may acquire practical skills to prevent relapses and reoccurrence of abuse. During the completion stage, the participant may also plan on what to do after the program is over.

13. Diversification and expansion of elder protection agency's cooperation system

As the name suggests, the work of the elderly protection agency is focused on the prevention of elder abuse and the “protection” of the abused elders. Therefore, it may be desirable for the agency to cope with abusers by sending them to the relevant institutions. However, upon

1) This section has been written by referring to *Development of a Treatment Program for Perpetrators of Child Abuse* by Han, I. et. al., Ministry of Health and Welfare, 2009

checking the cooperating entities of the Korea Elder Protection Agency (KEPA), this study discovered that most of the entities enlisted were related to the abused elders, and it was difficult to find agencies that specialized in dealing with the abusers themselves. Thus, there is need to diversify and expand the agency's cooperative system by including institutions that can professionally deal with abusers.

14. Mandating the development and implementation of a customized program for elder abusers

When found to be an elder abuser, the offender must first be prosecuted with criminal charges. At the same time as the prosecution, or after the prosecution is over, there is need to subject the offender to receive compulsory counseling and education programs. Such programs should be customized according to the type and severity of the abuse committed. The customized counseling and education programs can be organized by referring to counseling and education programs for child abusers.

In order to mandate customized counseling and education programs for elder abusers, Article 39-16 of the *Welfare of Older Persons Act* (recommendation of counseling and education for elder abusers) should be under consideration for change. It currently reads, '①Regarding elder abusers, the head of an elder protection agency may recommend that the abuser receive necessary support such as counseling, education, and psychological treatment.' This clause should be changed to make the support mandatory. Since the elder abuser would have been located by using the elder abuse determination index, there is need to increase the standards of the current index as means to 1) more strongly regulate and

restrict elder abuse behavior and 2) significantly reduce the possibility of abuse reoccurrence.

15. Health and capacity-building services for elder care providers

To prevent elder abuse caused by caregiver stress, it is necessary to provide health support services to elder care providers along with the *Vacation Support Program for Families with Demented Member* mentioned earlier. Caregiver stress management programs and caregiver capacity-building programs will aid in elder care providers receiving less stress and effectively relieving stress that comes from caring. This mitigation of stress will be effective in significantly reducing the danger of caregiver stress leading to abuse.

16. Rationalization in selection of individuals fit for having long-term care cost deduction

Elderly households who are neither on basic livelihood security nor in the next-lowest-income bracket are considered to be in the poor bracket with no benefits (welfare blind spot). For such households, the required expenses accompanying care would prove burdensome. Though they need long-term care services, they cannot avail of the services because they cannot afford the expenses needed. Consequently, the family then has to be solely responsible for the burden of care. This often leads to caregiver stress which has high potential for causing elder abuse. There is danger of not only physical abuse but also danger of neglect and abandonment due to excessive caregiver stress. Therefore, the burden for long-term care self-pay should be reduced to minimize the case where

services may not availed because the services are not affordable.

17. Improvement in statistics related to elder care and abuse

The main statistics on elder health are the *National Survey of Older Koreans*, the statistical report on the current status of elder abuse, statistics on elderly welfare facilities, and long-term care insurance statistics. In addition, the Ministry of Health and Welfare publishes annually the *White Paper on Elderly Welfare*; the *White Paper* contains statistics on elderly health. The statistics mentioned thus far need improvements in the following areas.

First is the *National Survey of Older Koreans*. The survey is conducted every three years in accordance with Article 5 of the *Welfare of Older Persons Act.* It is done as means of investigating the general health and welfare status of the elderly. The survey contains too broad in its reach and is thus limited in that it does not cover specific and in-depth issues. Care and abuse are also addressed as items in the *Survey*. Since the survey is the most basic but a critical policy data for the health and well-being of the elderly, the contents of the survey will need to be organized in terms of gender.

Second is the statistical report on the current status of elder abuse. This report is compiled and published in accordance with Article 39-5 (2) of the *Welfare of Older Persons Act*. The report presents basic statistics on abuse victims and perpetrators, along with in-depth analysis of the major issues related to elder abuse for the year of the report. However, in terms of gender, only a part of the data has been analyzed and published. This study has conducted gender classification for the statistics of elder abuse in 2012 ~ 2016 and has discovered that errors and limitations arising

from non-gender specific statistical data can be corrected. In particular, gender statistics are needed to identify the seriousness of elder abuse that occurs frequently in the family. Such gender statistics can be obtained by using gender classification when identifying the relationship between the elder abuse victim and the perpetrator.

Third is the statistics on elderly welfare facilities. The statistics show the number of facilities and holding capacities of the following: elderly residential facilities, elderly medical welfare facilities, elderly leisure welfare facilities, in-home elderly care facilities, elderly protection agencies, and elderly work support centers. However, the statistics for holding capacities do not provide gender data; thus, it is difficult to identify the number of men and women that the facilities can hold, respectively. However, considering that 1) the number of admission facilities has been increasing since the introduction of long-term care insurance and that 2) the number of elder abuse cases has increased in such facilities, it is necessary to identify the gender distribution according to the different types of facilities and provide gender-sensitive statistics.

Fourth is the long-term care insurance statistics for the elderly. The statistics provide data on the following: long-term care insurance coverage population, long-term care application / acceptance, long-term care benefits provided, long-term care institutions and their workforce, and long-term care finance statistics. Gender-specific statistics are provided on national and municipal levels. However, at the facilities level, the gender status of the elderly and the workforce are not provided. Therefore, it is necessary to provide gender-specific statistics of the elderly and workforce at the facilities-level.

18. Implementation of inter-gender and inter-generation gender-sensitive education to raise awareness of elder abuse

The issue of elder abuse has not received the same kind of social attention as child abuse or violence against women. This is also because women and the elderly are themselves socially vulnerable and isolated. However, the abuse of the elderly is being done undetected more than abuse in any other age groups. Additionally, victims who blame themselves need help in changing their self-perception. It is important to emphasize that reporting is the primary method for reducing and eradicating abuse. The importance of reporting should be stressed to all members of the household who can witness abuse. Therefore, awareness-raising education is needed for the family first and then for the local communities and the Korean society as a whole. The education should include contents dealing with the relationships between the elder abuse victims and the perpetrators. Abuse can happen between opposite genders, between the same genders, and also between generations. Education on abuse should be gender-sensitive and cover all phases of the life cycle.

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