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Cure vs. Care: Case in Korea

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Abstract: Medical sciences increase the life expectancy to the point that centenarian population is projected to quadruple over the next 30 years. Highlighting medical advancements and corresponding technological achievements is undeniably crucial for optimizing therapies and treatments; however, this focus significantly puts aside the critical goal of alleviating suffering in dying patients (Lionis et al., 2025), especially those in the end-of-life (EOL) stage. End-of-life is an emotional issue for everyone involved (patients, family, caregivers and religious community, etc.) which requires not only medical interventions, more importantly it (EOL) requires emotional support by and from every stakeholder in relieving pain and emotional stress emanated from isolation from family and friends, neglected by society and abandoned by government.

Keywords: End-of-Life, Palliative Care, Hospice Care, Long-term Care, Good Death, Elderly Misery, Solitary Death, Super-Age-Society, Well-Dying Act

INTRODUCTION

Improving end-of-life experience is a major challenge for many people who are experiencing successful aging. Yet, it should be pointed out that successful aging does not lead to quality end-of-life. Deaths are considered as high-quality-death when and if deaths come reasonably free from discomfort and pain based on patient's wishes surrounded by family and friends. Patients at the end-of-life stage are looking for comfortable surrounding which addresses pain and symptom management, awareness of pending death, patient's dignity, family presence, and communication among patient, family, and health care providers (Granda-Cameron and Houldin, 2012). "Good" death must be a self-aware death in which we grasp the situation of what is happening to patients (Scarre, 2012). In short, "good death" calls for dying with dignity, peacefulness, preparedness, awareness, adjustment and acceptance (Hart *et al.*, 1998). Among many criteria of "good death", family presence has been cited as the most important factor that the dying patients cherish during the final phase of their life (Kim and Lee, 2003)

MEDICAL SCIENCE AND MISERY OF DYING

It is irony and paradoxical to some extent that unparallel advancement in medical sciences in recent history also has created unexpected and unintended misery for those who are in and/or at the end-of-life stage. Modern family structure encourages single family formation where elderly population who are at the end-of-life cycle are isolated from their extended family. Isolation from family adds different type of emotional stress of abandonment from their extended family. Psychological effects on those at the end-of-life mainly stem from

depression and social isolation, loss of family and friends, spouse, physical deterioration leading to loss of independence, loss of self-esteem, views self as non-productive member of society which in turn prompts self-diminishing process.

Extended life expectancy, precipitated by medical sciences advancement and cheered by co-conspirators in pharmaceutical industries, but not emotionally supported by modern family structure, place those in their end-of-life cycle into deep depression to the point to end their life than prolong their misery. They are searching for "good death" rather than suffering from loneliness isolated from and abandoned by their family, friends and community. Many elderly people at this stage give up their will of living and looking for alternative way ending their life.

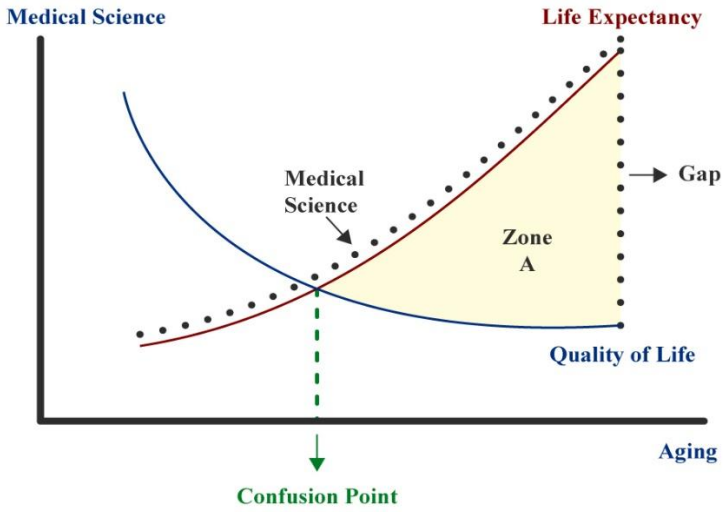

Figure 1: Medical Science, Drug and Misery of EOL (End-of-Life Care)

Figure 1 illustrates the paradoxical relationship between medical sciences, life expectancy and the degree of misery for older population who are at the end-of life cycle. As the pace of medical science advancement accelerating, the life expectancy also increases along with the medical science path. Increase in life expectancy, however, does not accompany the quality of life of those in their "twilight" zone. As a matter of fact, research reveals the quality of life for those in their end-of-life cycle is deteriorating as fast as new innovation in medical sciences but in opposed direction. The more "medical miracle", the higher level of misery for the elderly population who are in their end-of-life cycle stage. The gap between these two opposing trends, however, is getting wider creating so-called "misery zone" (Zone A). The Zone A is getting wider as life expectancy increases along with medical science advancement. For example, medical-related patents granted by the United States government saw a 76.3% increase from 30,429 in 2023 to 53,648 in 2024, leading to the technology's inclusion as a top of the field (Anaqua Analysis, 2024).

Seniors become confused at a certain point in their life where the life expectancy curve (once considered a joyful event) intersects the quality-of-life curve which is deteriorating over the life span. Medical advancement failed to anticipate the serious consequences it creates, misery of quality of late life. Curriculum in the medical schools has seldom addressed this late life human misery that they help to have created.

Intersection between medical life expectancy and quality of life lines would create "confusion point" for those in their "twilight zone". The lifetime dreams of enjoying their late life are gradually replaced by despair from loneness caused by isolation from family and/or friends, and abandoned by the government. Many elderly people at this stage of their life gradually lose their will to live and search for alternatives including ending their life (suicide). To many elderly populations at this stage, medical science advancement became a factor causing misery rather than celebration of their long-life.

The case is not limited to Korea. Recent report by the Center for Disease Control and Prevention, Americans 75 and over had the highest rate of suicide in 2021 and 2022. Isolation is one of the reasons that they take their own life (Centers for Disease Control and Prevention, 2023).

CASE IN KOREA

As of 2025, South Korea's GDP is approximately $1.71 trillion, ranking her as the 12th largest economy in the world by nominal GDP. (The Korea Times, July 31 2025). The country has a GDP per capita of $33,121, placing it at 36th among 197 countries. The life expectancy in Korea in 2024 was 83 years (women; 86 years and men; 80 years), one of the best countries among the economically advanced countries, even better than USA (81.4 years for female, 76.3 years for male, overall, 78.8 years). In addition, Korea has one of the lowest misery indices (Korea = 6.6; USA = 6.9, worst country in the world, Sudan = 375).

These positive statistics on surface would create illusion that everyone in Korea appears to be "happy and content: of their life. But reality is far from statistics reveal especially for elderly citizen. The national picture on wealth does not necessarily reflect economic and emotional well-being for seniors especially those who are at the end-of-life stage. For example, as of 2023, Korea's relative poverty rate among people aged 65 and older reached 39.8 percent - the highest among the 38 OECD member nations and nearly triple the OECD average of 14 percent. In 2023, 37.3 percent of Koreans aged 65 and older were still working - well above the OECD average of 13.6 percent and even surpassing Japan's 25.3 percent, despite its earlier transition into a super-aged society.

About 20 percent of older Koreans live alone which is projected to double by 2050. Korea has enjoyed the Confucians' family tradition and value where two or even three generations of family lived under one roof. Seniors, typically grandparents, play an important role as a family cornerstone. Interaction with vast family members provide seniors a joy of engagement and provides sense of "being", productive member in and for the family.

Disintegration of such extended family structure that has been respected and nurtured by many generations gradually isolate the older generation from extended family network. Seniors suddenly find themselves in an unchartered environment where they have to struggle to learn the new life style isolated from their extended family. Many seniors so isolated find their life unbearably and emotionally difficult. The country's senior suicide rate stands at 40.6 per 100,000 - more than double the OECD average of 16.5. The growing individuality and diminution of extended family have created unintended result of many older populations isolated from their extended family in their final stage of their life. More seniors are reportedly experiencing solitary death, e.g. people who die alone in social

isolation, cut off from family, relatives and others who have been close to them. Experts blame such trend by a mix of factors - more single-person households, rapid aging, weakened face-to-face relationships amid digitalization, shrinking community ties - all of which deepened social isolation. The Korean government has designated a 'lifelong response to social isolation' as a main cause of the solitary deaths.

The situation appears to be getting worse than before it is getting better. In December 2024, for example, Korea crossed into super-aged society status, with those 65 and older now comprising more than 20 percent of the population (The Korea Times, September 25 2025). This trend adds pressure on healthcare industries in general and for the elderly care facilities such as palliative and hospice facilities.

To cope with the growing demand for elderly care who are isolated from family and abandoned by society and government at their end-of-life stage, the Korean government in October of 2017, launched a pilot program for the Hospice, Palliative Care, and Life-Sustaining Treatment Decision-Making Act, also duped as the "Well-Dying Act". The law took full effect the following month, and between February 2018 and April 2019, just one year, more than 45,000 elderly patients have chosen to forgo life-saving medical assistance. What they fear the most is loneliness and isolation at their late life stemmed in part by medical intervention. Because the medical advancement rewards cure far better than care, it has created the "elderly misery" during their late life cycle.

The fact that so many elderly patients in their end-of-life stage opt out lifesaving medical intervention reflects to some extent that emotional pain from isolation is far worse than any benefit from medical intervention. It follows that many elderly patients at this stage prefer palliative care which provides specialized medical care for people diagnosed with a grave illness such as cancer or heart disease, and it can be integral to a patient's healing process. Alongside curative treatment, palliative care emphasizes patient's quality of life rather than curing their diseases.

WHO defines palliative care as an approach that improves the quality of life of patients and their families (emphasis added) who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. Palliative care is highly effective at relieving the pain and suffering of people living with and affected by life-limiting illness, optimizing their quality of life from early in the course of their disease until the end of their lives. It is neither to hasten nor postpone death, just provides patient comfort in the midst of their struggle to overcome the ultimate destination, death. Some scholars even argue that palliative care is a human right. According to this argument, under international law, there are two main sources for this right: the right to health and the right to be free from cruel, inhuman and degrading treatment (Brennan, 2007). Yet, less than 14% of people worldwide who need palliative care currently receive it (Linder, 2025).

It is ironic to notice that the world we are living in today where medical sciences in collaboration with drug industries advance wonder drugs that prolong our life, yet silent about the quality of life especially for those who are in their end of life. Medical science and quality of life in the late stage of our life seem to diverge separately as shown in Figure 1 creating unusual, but unforgiving reality; long-life due to medical intervention with miserable and lonely death because of it.

PALLIATIVE CARE IN KOREA

With industrialization, urbanization, and overall economic development, the household structure in Korea generally shifts from an extended to a nuclear form. The rate of family support for older parents began to decrease from 18.8% in 1970 to 9.1% in 1995 and 5.3% in 2015, consistent with the modernization of the Korean society. (Statistics Korea, 2015). Displaced seniors at their late life find themselves that home is no longer a common place of care for older adults and such role has been replaced by various care facilities.

One option emerged as an alternative place for cure and death is palliative care, term rarely used in Korea for many years. Palliative care requires societal understanding of this option where patients, their families and physicians can openly discuss death and plan for the end of life. It is a common practice in the Korean society to avoid the concept of "death" especially before the patients. Only about 8 percent of hospice patients who wanted to spend their final days at home died in their own residences, underscoring the gap between their wishes and practical barriers to dying at home. That gap reflects a surging demand for home deaths that Korea's hospice system has struggled to meet, constrained by staffing shortages and by the burdensome procedures families must struggle to comply with.

Nevertheless, in Korea, the number of hospice and palliative care beds has been steadily increasing. As of the latest data (Kwon *et al.*, 2021), there are 1,403 beds in 87 facilities which reflects a steady increase in the number of patients receiving hospice care. However, there are challenges, such as staffing shortages and procedural burdens that families face when a death occurs outside a hospital. Despite these challenges, the number of new hospice patients continues to rise, with many preferring to receive care at home.

The positive trend in homecare landscape in Korea, however, falls short compared with other advanced countries especially in OCED nations as shown in Figure 2. Average total long-term care spending in terms of GDP in 2019 for Korea is little over 10% whereas the same information for the OCED countries in average is about 15%, 5 percentage point differentials! Furthermore, there is a wide gap between Korea and average OCED spending on home-based long-term care as illustrated in Figure 3. Considering rapid increase in older population in Korea, so-called super-aged society where population age 70 and older surpasses those age 20 to 30 years old, need for homecare facilities will be accelerated consuming a bigger portion of healthcare spending in Korea (Figure 4).

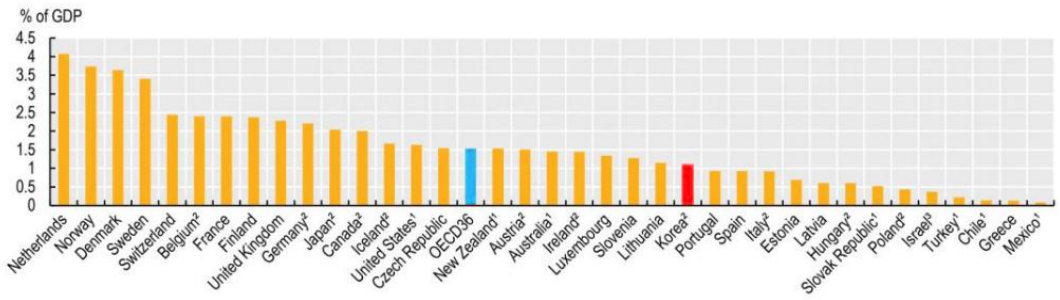

Figure 2: Total long-term care spending as a share of GDP in 2019 (or nearest year)

[Source: OECD (2021), *Health at a Glance*, OECD Publishing, Paris]

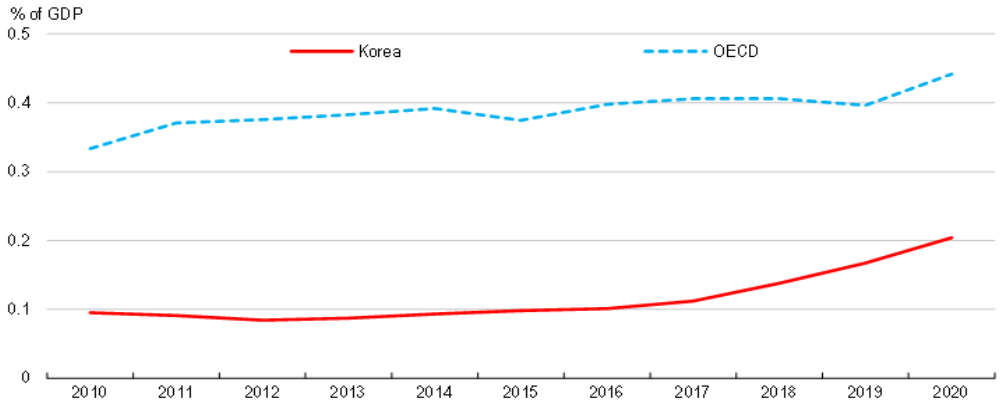

Figure 3: Public spending on home-based long-term care is relatively low in Korea

[Source: OECD (2022), *OECD Economic Survey of Korea*, OECD Publishing Paris]

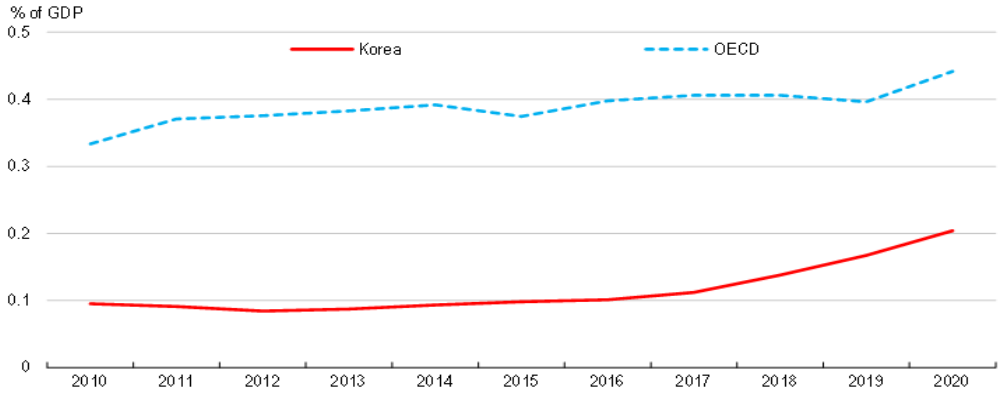

Figure 4: Trends in the share of the population aged over 80years

[Source: OECD (2021), *Health at a Glance*, OECD Publishing, Paris]

SUMMARY AND CONCLUSION

Life expectancy has been steadily improved due mainly to a rapid advancement of medical sciences. We celebrate a long-life as symbol of "hidden" wealth especially in most Asian countries in general and countries in Far Eastern nations in particular, such as China, Korea and Japan. As soon as the centenarian celebrates their longevity, a reality sets in as they discover the quality of life in their twilight years is less joyful than we used to have believed due in part to separation from family and abandoned by society and government. Disintegration of multigenerational family structures precipitate mental and psychological breakdown for those who live their life alone. Mental anguish coupled by physical deterioration prompt despair for living alone and seek for quick end of their life. More people in this situation decline medical intervention and seek for "good death".

Challenge for governments is NOT to prolong their longevities through medical intervention, rather to provide them with a place where they feel comfortable in waiting for their final destination, death. Palliative care provides a place where the dying patients find solace surrounded by family and care professionals. This research found that Korea,

one of the wealthiest countries in the world, lacks of facilities to accommodate the fast-growing seniors who need such facilities. It has been found that a long-term care is much more cost-effective compared to alternative modes (dying in hospital or home). It is recommended that Korea should strive to improve/increase the number of long-term care facilities at least the level of average that OECD countries enjoy at this time.

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