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Care as mission in super-aged societies: Theology and practice of the care-as-mission paradigm

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Rapid population ageing has confronted numerous societies, including South Korea, with a severe crisis of elderly isolation, poverty and care deficits. However, existing mission paradigms have failed to provide theologically adequate responses to this care crisis. This study aims to establish the Care-as-Mission Paradigm (CMP) as a theological framework for addressing the care crisis in super-aged societies and to explore its practical applicability. This research originates from the Korean context, which has become the world's fastest-ageing society, and analyses elderly care practices in British churches as comparative cases. The study critically integrates four theological traditions – *Missio Dei*, incarnational theology, diakonia and care ethics – to construct the theological foundation of CMP and qualitatively analyses cases from British churches. Care-as-Mission Paradigm derives three core components: Incarnational accompaniment, vulnerability-based mutuality and public engagement. British churches' collaboration with the National Health Service (NHS) Social Prescribing system demonstrates the practical validity of CMP. Care is not a subsidiary means of mission but an essential mode of participating in God's mission. Care-as-Mission Paradigm provides an integrative framework through which churches can respond to the care crisis of super-aged societies in theologically legitimate and practically effective ways.

Contribution: This article contributes to the intersection of missiology, diakonia studies and care ethics by reconceptualising care as an essential dimension of mission, thereby offering a theological response to the emerging missional context of super-aged societies. This aligns with HTS's multidisciplinary and public theological concerns, particularly expanding discussions on the church's public role in non-Western contexts.

Keywords: mission; diakonia; super-aged society; social prescribing; vulnerability; incarnational theology; care ethics; Korean church.

Introduction

The 21st century has witnessed unprecedented demographic transformations across numerous societies. South Korea exemplifies the fastest population ageing globally, having transitioned from an ageing society in 2000 to a super-aged society in 2025 – A mere 25 years (Ministry of Health and Welfare 2024a). The proportion of the population aged 65 years old and above has reached 20.6% and is projected to rise to 40.1% by 2050. More critically, social isolation among the elderly has intensified dramatically. Households comprising only elderly persons constitute 88.0% of all elderly households, while the relative poverty rate stands at 38.1% – Approximately, three times the Organisation for Economic Co-operation and Development (OECD) average (Ministry of Health and Welfare 2024b). In 2023, 3661 solitary deaths were recorded, and the phenomenon of 'elder-to-elder care' [Korean: 노노케어, *nono-care*] – wherein elderly children in their sixties and seventies care for parents in their eighties and nineties – has proliferated.

This care crisis occasionally manifests in tragic forms. Prolonged caregiving imposes physical, emotional and economic exhaustion upon family carers, sometimes culminating in caregiver homicide or joint suicide. Between 2006 and 2018, caregiver homicides claimed 213 victims, with perpetrators having provided care for an average of 6 years and 2 months. Contributing factors included economic hardship (48.0%), momentary emotional crisis (38.9%) and accumulated caregiving stress (38.0%) (Park 2021:135–136). These patterns reveal that care burdens transcend individual 'invisible labour', constituting a form of social violence engendered by the absence of public care systems.

The care crisis extends beyond the limitations of social policy, fundamentally entailing theological and ethical dimensions: The violation of human dignity, the rupture of relationships and the

dissolution of community. Care represents a universal ethic grounded in the inherent dependency and interdependency of human beings, constituting an essential practice that preserves and promotes human dignity (Lee 2023a:726).

Twentieth-century mission theology experienced significant paradigmatic shifts. As Bosch (1991) systematically articulated, the understanding of mission transitioned from an ecclesiocentric focus on church expansion to participation in God's mission [*Missio Dei*]. Nevertheless, care remains marginalised or instrumentalised within mission discourse. Traditional conversion-centred mission reduces care to a contact point for evangelism, while the church growth movement employs care as a marketing strategy for church expansion. Even the integral mission discourse that developed following the 1974 Lausanne Covenant, by juxtaposing evangelism and social responsibility in parallel, fails to fully recognise the missional essence of care. Although Padilla (2010:2,9) emphasised the integration of both dimensions, they remain positioned side by side rather than unified.

This study establishes the Care-as-Mission Paradigm (CMP) theologically and explores its practical applicability. Care-as-Mission Paradigm constitutes a theological-practical framework that understands care not as a subsidiary activity or instrument of mission but as an essential mode of participating in God's mission [*Missio Dei*]. This research critically integrates four theological traditions – *Missio Dei*, incarnational theology, diakonia and care ethics – to construct CMP's theological foundation, and validates its practical feasibility through analysis of British churches' elderly care practices.

Research methods and design

This study employs a qualitative research design combining theological construction with case analysis. Specifically, the research comprises a theological literature review and secondary case analysis. Firstly, through a literature review, four theological traditions are critically examined and integrated to construct CMP's theological foundation. Secondly, British churches' elderly-care cases are qualitatively analysed to explore how CMP's practical components are implemented.

The United Kingdom was selected as the analytical context for several reasons. Firstly, Britain experiences rapid population ageing and elderly isolation comparable to that of Korea. The proportion of the population experiencing loneliness surged from 11% in 2011 and 2012 to 31% in 2020, with 3.8 million persons aged 65 and above living alone (Bickley & Rich 2020:56–57). Secondly, Britain has developed an institutional model wherein churches function as official partners within the public welfare system through the National Health Service (NHS) Social Prescribing scheme (Rozario 2025:15,41). Thirdly, care ministries are implemented across diverse church traditions – Anglican, Catholic and Free Churches – enabling verification of CMP's theological universality. Fourthly, empirical research from institutions such as the Theos think tank has measured the social value of church care activities, facilitating objective evaluation. The British context thus functions as an instructive rather than directly transferable comparative reference point. While significant institutional differences exist – particularly the formal integration of churches into the NHS Social Prescribing system, which has no direct equivalent in Korea – the structural analogies in demographic trajectory, the intensification of elderly isolation and the shared theological commitment to community-based care make British practice analytically generative for Korean application. It must be acknowledged that this study draws exclusively on secondary sources – published think tank reports, institutional documentation and peer-reviewed literature rather than primary fieldwork; this constitutes a recognised methodological limitation, and the findings should be understood accordingly as illustrative rather than exhaustive.

This study utilised secondary empirical data on British churches' elderly care as analytical data, including reports from the Theos think tank (Bickley et al. 2020; Pennington 2020; Rozario 2025), Church Urban Fund research (2021) and reports from the Centre for Theology and Community (Ritchie & Brittenden 2024). Cases were qualitatively analysed using CMP's three components – incarnational accompaniment, vulnerability-based mutuality and public engagement – as the analytical framework.

Ethical considerations

This study constitutes a literature research utilising publicly available secondary data and does not involve human subjects. The research draws on published reports and academic literature and requires no ethics committee approval.

Theological foundations of care-as-mission paradigm

Missio dei and life-caring ministry

The core of *Missio Dei* theology lies in the recognition that mission originates in the Triune God. Bosch (1991:390) clarifies that *Missio Dei* does not merely shift the agent of mission from the church to God but affirms that the church participates in God's prior and ongoing redemptive mission. This mission aims not only at individual salvation but also at the transformation of social structures, the restoration of creation and cosmic reconciliation within God's Kingdom. Through a re-reading of John 3:16, we can confirm that the essence of God's mission is love for the world, with its ultimate purpose the restoration of life. As John 10:10 explicitly states, 'life in abundance' – the holistic and complete restoration of life – constitutes the telos of God's mission. This reframes God's mission not as an abstract concept but as a concrete life-caring ministry. This trinitarian grounding of mission is further developed by Bevans and Schroeder (2004:290–295), who articulate *Missio Dei* as the church's participation in the creative, redemptive and sanctifying

work of the Triune God – affirming that the church does not possess mission as its own project but is itself constituted by its participation in God's prior and ongoing mission to the world.

Scripture provides abundant testimony to God's essential care ministry. In Genesis 2:15, God commissioned humanity to 'keep' [שָׁמַר, *shamar*] creation, while the Exodus narrative presents God as the caring God who stands in solidarity with suffering Israel and liberates them (Ex 3:7) (Wright 2006:65, 272). In the Gospels, Jesus Christ's ministry is summarised in three dimensions: Teaching, proclaiming and healing (Mt 4:23), with healing and care accorded equal weight alongside teaching and proclamation. When 1 John 4:8 declares 'God is love', this signifies not an abstract attribute but love embodied as concrete care towards the world (Wright 2006:301–302, 416). Therefore, the church's mission essentially constitutes participation in God's life-caring ministry, and care represents the core content of mission.

Incarnational theology and vulnerability

The second theological foundation of CMP is grounded in the doctrine of the Incarnation. Philippians 2:6–8 depicts the Incarnation as an event of 'self-emptying' (kenosis). The declaration that Jesus Christ 'emptied himself, taking the form of a servant … becoming obedient to the point of death' reveals an ontological event wherein God relinquished omnipotence and chose vulnerability. Moltmann (1974: 204–205, 226) expressed this radical nature of the Incarnation through the concept of 'the crucified God'. According to Moltmann, God is not a transcendent observer who views human suffering and death from the outside, but an immanent companion who enters the midst of that suffering and experiences it together. On the cross, God himself was forsaken, suffered and was killed. This constitutes a fundamental challenge to traditional theological understandings of an immutable and impassible God, representing a revolutionary declaration that God is present in the midst of vulnerability and suffering (Moltmann 1974:281).

This incarnational theology carries significant implications. That Jesus Christ entered into the vulnerable human condition declares that vulnerability is not sin or defect but the original condition of creatures. Furthermore, vulnerability is the locus of God's presence. While traditional theology understood strength, perfection and self-sufficiency as the image of God, incarnational theology subverts this understanding. God is present in weakness, in dependency, in suffering (Moltmann 1974:227).

Human beings cannot live in isolation, depending on others' care throughout the entire course of life. Kittay (1999:36–37) termed this the 'universality of dependency', arguing that all humans require care at some point in their life cycle. Therefore, care is not charity for the weak or an exceptional circumstance but an essential relationship of human existence and a universal condition. The Incarnation demonstrates that God himself chose this vulnerability and dependency.

The missional implication of incarnational theology is evident in Jesus's declaration, 'whatever you did for one of the least of these … you did for me' (Mt 25:40), ontologically identifying himself with the hungry, thirsty, stranger, naked, sick, and imprisoned. Liberation theologian Sobrino (1978:300, 386) argues that Christ is present in the vulnerable. Consequently, caring for the vulnerable becomes an encounter with Christ. This care constitutes participation in God's concrete ministry of restoring human dignity and liberating the oppressed, thereby partially anticipating the coming of God's Kingdom in the world.

Diakonia: The essential mission of the church

Diakonia has been an essential dimension of Christian identity since the early church. Traditionally, it was understood as 'humble service' or 'material relief' and was sometimes regarded as hierarchically inferior to 'ministry of the word'. However, Collins's (1990:103–110) research revealed that diakonia signifies not simply 'lowly service' but 'authorised ministry'. The term denotes a commission or mission entrusted by an authoritative source and refers to the role of a messenger or go-between.

In the New Testament, diakonia encompasses the essential mission of the church: Apostolic ministry (Ac 1:17, 25), gospel proclamation (Col 4:17; 2 Tm 4:5) and the 'ministry of reconciliation' that God entrusted to us through Christ's reconciliation of the world to himself (2 Cor 5:18). Contemporary diakonia theology has accepted Collins's research, reaffirming diakonia as the ecclesiological and missiological essence of the church. Nordstokke (2011:13, 51–52) emphasises that diakonia is a theological concept that expresses the church's identity and mission, arguing that a church without diakonia is incomplete, as it is not an optional programme but rather the church's mode of existence. For Nordstokke, diakonia is not a mere charitable activity or a subsidiary church programme but participation in God's mission, entailing transformative and prophetic practice. Care-as-Mission Paradigm, building upon this discourse, argues that if diakonia is an essential element of the church, it must necessarily become a core dimension of mission.

However, diakonia theology also has limitations requiring supplementation. Firstly, traditional understandings of diakonia overlook the power imbalances and asymmetries inherent in care relationships, potentially leading to paternalistic practices that disregard the care recipients' autonomy (Dietrich et al. 2017:13–15). Secondly, diakonia has been confined to the private sphere. Diakonia has historically focused primarily on internal church relationships or interpersonal relations, with weak public and political dimensions. Historically, care has been restricted to the private sphere and thus excluded from political discourse (Dietrich et al. 2017:4, 42). Care-as-Mission Paradigm's third component, public engagement, responds directly to this

limitation. By grounding the church's participation in public welfare systems theologically – as prophetic witness to God's shalom – CMP provides the missional rationale that enables diakonia to move from the private sphere of charity into the public sphere of structural advocacy and institutional partnership.

Theological integration of care ethics

Care-as-Mission Paradigm seeks to theologically integrate the insights of contemporary care ethics regarding interdependency and relationality. Care ethics, which emerged as a philosophical discourse through the work of Carol Gilligan and Nel Noddings in the 1980s, was extended into political philosophy by Joan Tronto. Tronto (2013:19) defines care as 'everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible'.

Care ethics provides three core insights. Firstly, it takes relationality as its fundamental premise, understanding humans not as independent individuals but as interdependent beings. Secondly, it emphasises the universality of vulnerability – that all humans require care at some point in their life cycle. Thirdly, it ascribes political significance to care, arguing that care is not confined to the private sphere or individual virtue but constitutes a social and communal obligation, thereby transforming care issues into matters of public responsibility (Tronto 2013:18, 30, 146).

Building upon these insights, scholars have extended care discourse from individual ethics to social-structural dimensions. Kittay (1999:36–37) argued through the concept of 'double dependency' that care must be transformed into an essential matter of social structure. Ueno approached public responsibility for care from a sociological perspective, at the level of institutional reform, arguing that care must transition 'from charity to right, from paternalism to contract', reorganising care around the subject – the person with rights (Ueno 2024).

Care-as-Mission Paradigm theologically appropriates these insights while supplementing them with the distinctive resources of Christian theology. Firstly, human relationality is interpreted through koinonia. The early church shared possessions and distributed them to each according to need, devoting themselves to fellowship (Ac 2:44–45), while the concept of the body of Christ in 1 Corinthians 12 demonstrates a relational and interconnected network of giving and receiving care (Cho 2020:350–352). Secondly, vulnerability is reinterpreted through the theology of the cross. The proclamation that 'even God was crucified in weakness' (2 Cor 13:4) is deeply connected to God's self-emptying love, suggesting that the essence of care is love (Moltmann 1974:227, 249). Thirdly, the political dimension of care is clarified through public theology. Care-as-Mission Paradigm reconceptualises care as a public value and practice, arguing that the church must pursue the common good of society as a whole, beyond individual salvation, and address structural and political root causes (Tronto 2013:7, 61–62). While Tronto's framework is grounded in secular political philosophy, CMP does not merely import this argument but theologically transforms it: Where Tronto grounds the political obligation of care in human interdependency, CMP grounds it in participation in God's own caring mission towards the world [*Missio Dei*]. The political urgency Tronto identifies is thus reframed as prophetic witness to the shalom of God's Kingdom (Wright 2006:65, 301–302), and the church's public engagement becomes not merely a social responsibility but an expression of its missional identity.

This paradigm adds a transcendent and eschatological dimension that care ethics often lacks. Care is not confined to the extension of biological life but interpreted from the perspective of eternal life (1 Jn 3:14), gaining new meaning and power within a relationship with God (Eurich 2017:5). Moreover, care is a sign and foretaste of God's Kingdom. Social transformation through care witnesses to the 'already' of God's Kingdom, but the complete overcoming of sin and structural evil belongs to the 'not yet' dimension awaiting Christ's return (Nordstokke 2009:36–37). Therefore, CMP guards against excessive optimism regarding care practice, pursuing humble and faithful witness to God's Kingdom.

Framework of care-as-mission paradigm: Three core components

From the integration of four theological foundations, CMP's three core components are logically derived. This represents a transition from the theological legitimacy question of 'Why does care constitute mission?' to the practical specificity question of 'How shall we practise care as mission?' The four theological foundations converge into CMP's three components, with each component being both a direct consequence of specific theological foundations and complemented by others. *Missio Dei* and incarnational theology present the methodology of 'how to enter', incarnational theology and the relationality and vulnerability of care ethics define 'what kind of relationship to form' and diakonia and the political dimension of care ethics present the public dimension of 'how to extend socially'.

Initially, *incarnational accompaniment* is derived from *Missio Dei* and incarnational theology, signifying embodied presence that intentionally and continuously enters into others' concrete life worlds to share their joys and sorrows. 'The Word became flesh and dwelt among us' (Jn 1:14), 'emptied himself, taking the form of a servant' (Phlp 2:7) – these witness to the ontological event of God directly entering into human existential reality (Dietrich et al. 2017:16–17).

This is concretised in four practical dimensions. Firstly, physical proximity means going directly to others' spaces. This aligns with Jesus's active presence in peoples' lived realities, 'going about' (Nordstokke 2011:14–15). Secondly, temporal continuity means forming long-term relationships rather than short-term contacts. Partnership must be

maintained long enough for friendships to develop (Dietrich et al. 2017:25–26). Thirdly, emotional openness includes sharing one's own vulnerability. It is important that care providers are personally moved in encounters with others, relating to sharing all things among family members – joys and sorrows, hopes and fears (Dietrich et al. 2017:24, 199). Fourthly, cultural adaptation means adjusting oneself to others' rhythms and ways. Christian care providers must recognise their cultural biases and provide assistance within the context of others' cultures, values and household circumstances (Dietrich et al. 2017:226–227). Care-as-Mission Paradigm addresses these challenges through its component framework. Cultural bias is mitigated by vulnerability-based mutuality: When caregivers acknowledge their own cultural situatedness as a form of vulnerability and adopt a posture of learning, cultural adaptation becomes a relational practice rather than a technical obstacle. Power asymmetries in care relationships must be addressed through democratic practices that recognise the voice and participation of care receivers (Tronto 2013:139–140). Building on this insight, CMP interprets care encounters as reciprocal relationships in which care recipients' agency becomes constitutive of the caring relationship.

Secondly, *vulnerability-based mutuality* is derived from incarnational theology and care ethics, beginning with the recognition that both the caregiver and the care recipient are fundamentally vulnerable beings. This fundamentally subverts traditional charitable structures. While charitable structures presuppose a fixed binary between givers and receivers, structurally entrenching unidirectional relationships and power inequality, vulnerability-based mutuality acknowledges that all persons are vulnerable beings requiring care at some point in their life cycle, pursuing bidirectional mutual learning and caring relationships and aiming for dynamic fluidity of power (Tronto 2013:139–140).

Vulnerability-based mutuality is implemented through four concrete practices. Firstly, disclosure of vulnerability means caregivers honestly sharing their own weaknesses. Secondly, a posture of learning means regarding care recipients as teachers and seeking to learn from them. Thirdly, fluidity of roles acknowledges that who helps and who receives is not fixed but can change according to circumstances. Fourthly, redistribution of power includes enabling those directly affected to participate in decision-making processes (Tronto 2013:30–31, 103–104, 139–146). Together, these four practices constitute CMP's structural response to the paternalistic risks inherent in asymmetrical care relationships: By positioning caregivers as learners, affirming fluid role boundaries and redistributing decision-making power to those receiving care, vulnerability-based mutuality systematically dismantles the helper and recipient hierarchy that characterises traditional charitable models.

Thirdly, *public engagement* is derived from diakonia and the political dimension of care ethics, signifying participation in promoting the common good of society as a whole, beyond individual salvation or internal church concerns. It particularly includes structural and political participation that advocates for the rights and dignity of vulnerable groups and transforms policies and institutions. Biblical tradition confirms this: Jeremiah 29:7 commands seeking the welfare of the community; Amos 5:24 emphasises social justice and Luke 4:18–19 records Jesus proclaiming a mission of liberation and restoration (Nordstokke 2011:78–79). Public engagement transcends traditional charity. While charity remains at the level of interpersonal relationships and symptom alleviation, public engagement seeks systemic change, addresses root causes of problems and actively operates in the public sphere (Eurich 2015:5–6).

The three components form relationships that are both sequential and mutually constitutive. Incarnational accompaniment presents the methodology of entering into others' lives, the nature of the relationships formed therein is vulnerability-based mutuality and these personal relationships expand into public engagement, pursuing social structural change. These three elements do not constitute a linear sequence but rather an organic whole that dynamically interacts. When incarnational accompaniment and mutuality combine, deep and equal relationships form; when mutuality and public engagement meet, advocacy movements led by those directly affected become possible and when public engagement and incarnational accompaniment connect, field experience is reflected in policy. Thus integrated, CMP simultaneously secures theological legitimacy and practical specificity, becoming an integrative framework that demonstrates that care and mission are essentially one.

Case analysis of British churches' elderly care

Rationale for selecting British cases

Before analysing specific cases, it is necessary to clarify why British churches provide appropriate case studies for examining CMP implementation. The United Kingdom presents a particularly instructive context for several reasons. Firstly, Britain experiences demographic challenges comparable to those in Korea and other rapidly ageing societies. The Office for National Statistics reports that loneliness has become a significant public health concern, with the proportion of the population experiencing loneliness surging from 11% in 2011 and 2012 to 31% in 2020 (Bickley & Rich 2020:56–57). This has been associated with increased risks of depression, cardiovascular disease and dementia, placing additional burdens on the NHS (Ryan 2017:18–19).

A structured comparison of the two national contexts substantiates the study's analogical basis. Demographically, South Korea's population aged 65 years old and above reached 20.3% in 2025, projected to exceed 40% by 2050 (Ministry of Health and Welfare 2025), while the United Kingdom's equivalent stood at approximately 19% in 2022 with comparable upward projections. Both countries exhibit

intensifying elderly isolation: Korea recorded 3661 solitary deaths in 2023 (Ministry of Health and Welfare 2024a), with approximately 72.8% of elderly-headed households comprising only elderly persons – 37.8% living alone and 35.0% as elderly-only couples – and a relative poverty rate of 38.1% among those aged 65 years old and above, approximately three times the OECD average (Ministry of Health and Welfare 2025) – while in the United Kingdom, 3.8 million persons aged 65 years old and above live alone (Age UK 2019, cited in Bickley & Rich 2020:57), and the Office for National Statistics recorded that 7.2% of adults reported feeling lonely 'often or always' by early 2021 (ONS 2021). The critical divergence lies in institutional response: British churches have developed formal partnerships with the NHS through the Social Prescribing system, functioning as recognised public welfare partners (Pennington 2020:76–77; Rozario 2025:15), whereas Korean churches operate primarily within informal, congregationally bounded care frameworks without equivalent institutional integration (Min & Song 2016:603–604; Son 2025:185). This institutional gap is precisely what renders the British case analytically instructive: CMP, derived from British practice, offers Korean churches a theologically grounded pathway towards the public engagement that transforms congregational care into recognised community assets.

Secondly, British churches have developed sophisticated institutional frameworks for engaging with public welfare systems while maintaining theological identity. The Anglican parish system, in particular, provides a structural basis for churches to function as 'anchors' in their communities, with each church bearing pastoral responsibility for a defined geographical area. This institutional infrastructure has facilitated the development of formal partnerships between churches and the NHS through Social Prescribing schemes (Rozario 2025:6).

Thirdly, empirical research conducted by organisations such as the Theos think tank has systematically documented and measured the social value of church-based care activities, enabling evidence-based analysis. In 2017, 86% of Church of England churches operated lunch clubs, and 70% provided befriending services (Pennington 2020: 76–77). This widespread implementation across diverse denominational contexts enables examination of CMP's theological universality.

Implementation of incarnational accompaniment

British churches' elderly care cases effectively implement the four dimensions of incarnational accompaniment across diverse organisational forms – from professional Christian charities to local congregational initiatives. It should be noted that the cases examined here represent a selected range of instructive examples and are not intended to suggest uniformity across all British churches; rather, they illustrate how CMP components are instantiated in specific, well-documented contexts.

Physical proximity and temporal continuity

The St Vincent de Paul Society, established in Britain in 1844 with approximately 8000 members, is one of Britain's largest Catholic charities. In 2013–2014 alone, the Society provided 579 664 h of volunteer service, supporting 81 308 individuals and families (Bickley et al. 2020:20). The Society's core activity involves continuously visiting vulnerable and lonely people and forming friendships. A distinctive feature is that it is 'not only available in specific crisis situations, but continues to visit people regardless of how urgent a particular meeting might be'. This consistency and depth of relationship is what makes the activity effective (Bickley et al. 2020:24, 42).

Befriended, a Christian charity established in 2017 in Mid-Sussex exemplifies how local churches can systematically address elderly isolation. The organisation operates befriending programmes (face-to-face visits and telephone calls), exercise classes, including stretching set to Psalms ('Befriended Balance'), monthly tea parties (averaging over 100 attendees), bereavement support, care home chaplaincy, coach trips and a community choir (Rozario 2025:74–77). All activities take place in church buildings, and volunteers and leaders are mostly church members, combining physical proximity through church premises with temporal continuity through regular meetings. Significantly, Befriended maintains close collaboration with Social Prescribing Link Workers (SPLWs), regularly receives referrals for elderly patients experiencing loneliness or isolation and sends bimonthly newsletters to over 1000 SPLWs to maintain continuous communication (Rozario 2025:76).

The Anglican parish system provides institutional infrastructure for physical proximity. Parish churches are distributed throughout England, with each bearing responsibility for a defined geographical area. This enables churches to function as accessible spaces in their communities. As one researcher noted, church buildings themselves are perceived as 'safe and accessible spaces' where SPLWs can confidently refer patients (Rozario 2025:47).

Emotional openness

When a member couple of the St Vincent de Paul Society lost their daughter in a car accident, they received condolence cards from many people they had been visiting, and many attended the funeral. The couple said, 'The people we thought we were supporting came and supported us', noting this as an excellent example of 'genuine friendship relationship'. This experience reveals that care relationships are not unidirectional and that caregivers themselves are vulnerable beings (Bickley et al. 2020:42–43).

Cultural adaptation

The Karis Neighbour Scheme, initiated in 1997 by the Karis Medical Centre in Birmingham, is a pioneering model of social prescribing that connects general practitioner (GP) surgeries with churches and integrates medical and spiritual care. Christian GP doctors recognised that people's emotional, spiritual and social needs are as important as physical needs.

They observed that one-fifth of GP appointments were actually requests for help with non-medical social issues such as loneliness, housing and debt. As a Christian practice, they envisioned a role for churches in helping people in the community (Rozario 2025:6).

The Karis Neighbour Scheme provides comprehensive community support, including befriending for older people, chaplaincy services and practical assistance. The chaplaincy service enables patients to explore spiritual health issues – questions of meaning and purpose related to major life events such as birth, death and loss. The chaplain adapts to patients' worldviews and spiritual language, embodying cultural adaptation (Rozario 2025:52–53, 83).

Implementation of vulnerability-based mutuality

Mutual relationships beyond charity

The St Vincent de Paul Society case powerfully demonstrates that the roles of 'giver' and 'receiver' are not fixed but fluid. As documented above in the incarnational accompaniment section, the St Vincent de Paul couple who received condolence cards from those they had been visiting powerfully demonstrates this fluidity: Those regarded as care recipients became caregivers in the moment of grief, confirming that vulnerability-based mutuality is an experienced ecclesial reality, not a theoretical aspiration (Bickley et al. 2020:42–43).

That, on average, over 100 people attend Befriended's monthly tea parties demonstrates that participants are not merely passive service recipients but agents jointly creating community. The tea parties provide a space where participants can contribute, share their stories and build relationships with one another, rather than merely receive services. Exercise classes, including stretching set to Psalms, combine physical activity with spiritual elements, providing participants not merely with exercise services but with a shared experience of the faith community's spiritual resources (Rozario 2025:76).

Activation of elderly leadership

St Barnabas Church in Walthamstow, East London, exemplifies an approach that deliberately develops and engages elderly members as leaders rather than merely recipients. The church's approach developed as part of a community organising project, focusing not simply on providing services but on nurturing elderly leadership and maintaining their networks (Ritchie & Brittenden 2024:43).

Church leader Averil noted that 'St Barnabas elders add depth to the church family with their wisdom, mentoring young people and parents' (Ritchie & Brittenden 2024:43). The church utilises health walking clubs and Memory Cafés to help elderly members maintain their networks while integrating them into broader church activities. Through this community organising approach, elderly persons discover their purpose and feel a sense of belonging to the church and community (Ritchie & Brittenden 2024:44).

This approach is distinctive in viewing elderly members as valuable assets and in utilising their wisdom and experience to create activities that involve other elderly people in the local community. It represents an approach that sees elderly care not as one-sided relief but as part of mutual, relationship-based community strengthening.

Implementation of public engagement

Institutional integration with the National Health Service social prescribing system

The most distinctive and significant feature of British churches' elderly care is close institutional integration with the NHS Social Prescribing system. Social Prescribing is an innovative healthcare model, whereby medical professionals refer patients to non-medical services in the community, effectively addressing the social determinants of health (Pennington 2020:6–8; Ryan 2017:18–20). Churches function as core partners in this system.

Social Prescribing Link Workers (SPLWs) are well acquainted with the various activities operated by faith groups, identifying churches' strengths in 'community' and 'support' (Rozario 2025:25). Befriended sends newsletters bimonthly to over one thousand SPLWs to maintain continuous communication, while the Karis Neighbour Scheme collaborates directly with GP surgeries to receive patient referrals. In 2019, the Salvation Army and the Catholic St Vincent de Paul Society supported tens of thousands of people through this system (Rozario 2025:41).

The 2024 Lord Darzi report and Health Secretary Wes Streeting emphasised that the NHS should shift from 'diagnose and treat' to 'predict and prevent', moving towards a 'Neighbourhood Health Service' (Rozario 2025:56). Churches are positioned as strategic partners in preventive healthcare for three reasons. Firstly, physical infrastructure: Church buildings are distributed throughout Britain and function as hubs for community activities. Secondly, human resources: Churches possess a distinctive capacity to mobilise passionate and committed volunteers. Thirdly, social capital: Churches foster community trust and cohesion through deep networks and strong leadership. These resources demonstrate that churches are not merely service providers but core elements of community resilience (Rozario 2025:6, 31).

Community collaboration platforms

Broadmead Community Church in Northampton, a Baptist church, has established itself as a successful model of social prescribing and public health collaboration within the local community. The church serves as a hub for local community groups, with SPLWs referring patients to these groups, establishing close collaborative relationships (Rozario 2025:47).

The church operates various programmes that address loneliness among the elderly: Lunch clubs, well-being cafés, exercise groups and mental health courses. These programmes help elderly people maintain social connections and cope with life transitions such as bereavement (Rozario 2025:47).

The most notable collaborative model is the 'Community Collaboration Forum'. From September 2021 to September 2022, the church conducted local community conversations with GPs and Social Prescribing link workers, organising workshop groups on social isolation and mental health, which led to the launch of a 'Social Prescribing and Voluntary Sector Forum'. Rebranded as the 'Community Collaboration Forum' since 2023 and operated bimonthly, this forum involves multiple churches, public health, police, libraries, GPs and local partnership officers, functioning as 'a frank and informal space that allows networking, building relationships and trust, and sharing information and expertise' (Rozario 2025:47). This represents a best practice case of utilising the church's convening capacity to regularly gather community stakeholders and lead them towards collaborative solutions.

Demonstration of social value

The support services provided by British churches have been empirically demonstrated to relieve NHS pressure and generate savings of £8.4 billion annually in additional costs that would otherwise fall on the public health system (Pennington 2020:76–79; Rozario 2025:48–49). This quantification of social value is significant not merely economically but theologically, demonstrating that church care ministry has a concrete, measurable impact on community well-being.

More importantly, this engagement promotes social justice. Churches advocate for the rights and dignity of the most vulnerable elderly people – particularly those suffering from poverty, isolation and dementia – thereby practising social justice. The church functions not merely as a service provider but as a prophetic voice advocating for structural change.

Integration of worship and social action

A notable feature of British churches is the integration of worship and social action. One church's 'Agape' service involves the congregation sitting around tables sharing bread and soup before Gospel meditation; in another area, it is expressed that 'every act of hospitality has an act of worship attached to it'. Importantly, worship elements are not compelled. According to a minister, for some people, midweek church visits are 'the only place they feel loved, safe, and have a sense of belonging', attributable to both meals and worship elements. Many participants do not attend Sunday services, but through these Wednesday lunch gatherings, faith grows and discipleship occurs (Church Urban Fund 2021:89–90). This demonstrates a balance of maintaining theological identity without instrumentalising mission as a means of conversion.

Discussion

Key findings

The key findings of this study are as follows. Firstly, CMP secured theological legitimacy for reconceptualising care as an essential dimension of mission through critical integration of four theological traditions – *Missio Dei*, incarnational theology, diakonia and care ethics. This integration demonstrates that care is not merely a subsidiary activity or instrumental means of mission but constitutes participation in God's own caring ministry toward creation. Secondly, CMP's three components – incarnational accompaniment, vulnerability-based mutuality and public engagement – were confirmed to be implemented in elderly care cases within British churches. The St Vincent de Paul Society, Befriended, Karis Neighbour Scheme and St Barnabas Church each exemplify different dimensions of CMP while demonstrating their interconnection. Thirdly, the collaboration model with the NHS Social Prescribing system demonstrated that churches can function as core partners in the public welfare ecosystem beyond the private religious sphere, contributing measurably to community well-being.

Relation to existing research

This study extends Bosch's (1991) *Missio Dei* theology, Nordstokke's (2009, 2011) diakonia theology and Tronto's (2013) care ethics, integratively reconstructing them within the framework of mission theology. While existing integral mission discourse juxtaposed evangelism and social responsibility in parallel, CMP overcomes this dualism by positioning care itself as an essential component of God's mission. The distinction is significant: Integral mission discourse tends to present proclamation and social action as two equally important but ultimately distinct components of Christian mission, whereas CMP argues that care itself is mission, not alongside proclamation but as a form of proclamation.

Furthermore, the study sought to resolve the tension between theological identity and professionalism in diakonia as raised by Eurich (2015, 2017) through the dialectical integration of incarnational accompaniment and public engagement. Eurich identified a 'double bind' facing Christian social workers, caught between maintaining theological distinctiveness and meeting professional standards. Care-as-Mission Paradigm addresses this tension by showing how incarnational accompaniment (maintaining theological identity through embodied presence) and public engagement (professional collaboration with public systems) can be held together rather than in opposition.

The study also contributes to emerging scholarship on public theology in non-Western contexts. While much public theology discourse has emerged from Western European and North American contexts, CMP offers a framework applicable to the rapidly ageing societies of East Asia, particularly South Korea, while drawing on best practices from the British context. This cross-contextual approach demonstrates both the universality of CMP's theological foundations and the contextual specificity of its practical implementation.

Strengths and limitations

The strength of this study lies in providing theological argumentation for the missional essence of care and

supporting this with empirical cases. By integrating four distinct theological traditions and testing the resulting framework against contemporary church practice, the study offers both theoretical depth and practical relevance. The use of empirical research from organisations such as Theos enables evidence-based evaluation of CMP's implementation.

However, limitations are evident. Firstly, British cases are based on specific institutional arrangements, such as the NHS Social Prescribing system; direct transfer to contexts like Korea requires contextual adaptation. Secondly, institutional integration with public systems risks weakening the church's prophetic voice, as churches may become reluctant to criticise structural causes of problems. Thirdly, volunteer-dependent models have sustainability limitations. Fourthly, maintaining theological identity without instrumentalising care requires ongoing discernment.

These limitations underscore the importance of the eschatological tension that CMP presents. Social transformation through care witnesses to the 'already' of God's Kingdom, but complete overcoming of sin and structural evil belongs to the 'not yet' dimension awaiting Christ's return. Therefore, churches should guard against excessive optimism in care practice, while witnessing to God's Kingdom with humility and faithfulness, recognising the limitations of human effort.

Implications and recommendations

Theological implications

Care-as-Mission Paradigm argues that care is not the means but the content of mission, not strategy but essence. This calls for the reconstruction of mission theology. In super-aged societies, churches should not dualistically separate soul salvation from social care but understand care itself as a missional practice that witnesses to God's Kingdom. This has implications for theological education, which should integrate diakonia and care ethics into missiology curricula rather than treating them as separate disciplines.

Furthermore, CMP's emphasis on vulnerability-based mutuality challenges dominant models of mission that presuppose asymmetrical relationships between those who have (resources, knowledge, salvation) and those who lack. The recognition that caregivers are themselves vulnerable beings who both receive and give transforms the missionary encounter from one-way transmission to mutual exchange.

Practical recommendations for churches

Firstly, churches need to systematise relationship-centred care programmes, such as lunch clubs and befriending networks, by moving beyond one-off events to sustained engagement. Secondly, elderly persons should be recognised not as care recipients but as resources who contribute to the community through intergenerational ministry. Thirdly, churches should build partnerships with community health organisations and participate in public welfare systems while maintaining theological distinctiveness. Fourthly, churches should actively participate in policy formation, advocating for vulnerable elderly persons. Fifthly, churches should develop systems to measure and communicate the impact of their care ministries.

Application of care-as-mission paradigm to the Korean context

The foregoing analysis demonstrates that CMP is grounded in verified practice, and existing Korean church scholarship confirms that its core components are contextually viable. Firstly, regarding incarnational accompaniment, Korean churches already operate befriending visits, homebound elder support and dementia care programmes that embody the dimensions of physical proximity and temporal continuity identified in CMP (Kim 2025:128–135; Min & Song 2016:610–613). However, these activities tend to remain within a service-delivery paradigm. Care-as-Mission Paradigm reframes them as embodied participation in God's mission, thereby offering a theological reorientation that interprets elderly loneliness not merely as a social issue but as a theological concern requiring a missional response. Secondly, regarding vulnerability-based mutuality, the age-integrated church model proposed by Lee (2023b) – which advocates removal of generational barriers and active incorporation of elderly members as leaders and mentors – represents a Korean ecclesiological expression of CMP's second component. Son (2025:182–186) further argues that Korean churches' theological anthropology must shift from viewing the elderly as burdens to recognising them as bearers of the *Imago Dei* [Image of God], whose wisdom constitutes a missional resource. Thirdly, regarding public engagement, while Korean churches lack a direct equivalent to the NHS Social Prescribing system, Korea's statutory care architecture – comprising the *Long-Term Care Insurance Act* (Republic of Korea 2007) and the *Welfare of the Aged Act* – establishes the legislative framework within which community care operates, creating structured opportunities for church-based care to be formally recognised and resourced within the national welfare system. The government's emerging Community-Integrated Care framework presents an analogous institutional opportunity to the NHS Social Prescribing model (Son 2025:180–181). Min and Song (2016:615–616) document that Korean churches already possess the human, material and facility resources – buildings, trained volunteers, community networks – that position them as natural partners in this emerging infrastructure. Care-as-Mission Paradigm provides these existing Korean impulses with a unified theological framework that integrates what has hitherto been practised in fragmented form.

Conclusion

This study established the CMP as a theological framework that responds to the care crisis in super-aged societies. Care-as-Mission Paradigm integrated *Missio Dei*, incarnational theology, diakonia and care ethics to derive three components: Incarnational accompaniment, vulnerability-based mutuality and public engagement. Analysis of elderly care cases in British churches demonstrated that CMP is a practicable

missional approach. In particular, the collaboration between British churches and the NHS Social Prescribing system demonstrated that CMP can function as a recognised public health partner – offering Korean churches a contextually adaptable model for institutional public engagement.

Care is not a subsidiary means of mission but an essential mode of participating in God's mission. Just as Christ's incarnation was embodied in solidarity with the most vulnerable, churches encounter Christ and witness to God's Kingdom through caring for vulnerable elderly persons. Super-aged societies are not merely demographic changes but theological challenges that demand the reconstruction of the church's missional identity. The evidence reviewed in this study – from Korean church scholarship documenting CMP-consonant practices already in operation (Kim 2025; Lee 2023b; Min & Song 2016; Son 2025) to the emerging policy infrastructure of Korea's Community-Integrated Care framework – indicates that the conditions for CMP implementation are not merely aspirational but structurally emergent. Korean churches that adopt CMP as an integrative theological framework are positioned to become recognised partners in public elderly care, embodying the missional identity that super-aged societies both require and represent as a theological calling.

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Song Kon Lee: Conceptualisation, Formal analysis, Funding acquisition, Methodology, Project administration, Writing – original draft, Writing – review & editing. The author confirms that this work is entirely their own, has reviewed the article, approved the final version for submission and publication and takes full responsibility for the integrity of its findings.

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